IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-971

STATE OF NORTH CAROLINA EX. REL. SARAH T. MORROW; STATE OF NEBRASKA; AMERICAN MEDICAL ASSOCIATION; and NORTH CAROLINA MEDICAL SOCIETY, *Appellants*,

v.

JOSEPH A. CALIFANO, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC.; and NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS, *Appellees*.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

JURISDICTIONAL STATEMENT

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Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

JURISDICTIONAL STATEMENT

Appellants seek review of the decision of the United States District Court for the Eastern District of North Carolina, entered on September 22, 1977, granting the motion of appellee Joseph A. Califano for summary judgment and dismissing appellants' complaint. That complaint alleges that the National Health Planning and Resources Development Act of 1974 (42 U.S.C. §300k *et seq.*) is unconstitutional and seeks a permanent injunction against the enforcement of that act.

OPINION BELOW

The opinion and order of the United States District Court for the Eastern District of North Carolina dated September 22, 1977, which is unreported, is annexed hereto as Appendix A.

JURISDICTION

The State of North Carolina instituted this action for injunctive and declaratory relief pursuant to 28 U.S.C. §§1331, 2201, and 2202. The action challenges the constitutionality of the National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 2226, 42 U.S.C. §300k *et seq.* The State of Nebraska, the American Medical Association, and the North Carolina Medical Society subsequently intervened pursuant to Rule 24(b) of the Federal Rules of Civil Procedure.

A three-judge district court was convened below pursuant to 28 U.S.C. §2282.[1] On September 22, 1977, the District Court entered final judgment adverse to appellants, and notice of appeal was filed in that court on November 9, 1977. A copy of the notice of appeal is annexed hereto as Appendix B.

Jurisdiction to review by direct appeal the order of the District Court is conferred by 28 U.S.C. §1253.

QUESTIONS PRESENTED

(1) Whether an Act of Congress requiring a state to enact legislation admittedly repugnant to that state's constitution, under penalty of forfeiture of all benefits under

[1]Section 2282 was repealed by Pub. L. 94-381, §2, 90 Stat. 1119, but the repeal was not applicable to any action commenced on or before August 12, 1976. This action was filed on April 27, 1976.

approximately fifty long-standing health care programs essential to the welfare of the state's citizens, violates the Tenth Amendment and fundamental principles of federalism.

(2) Whether use of the Congressional spending power to coerce states into enacting legislation and surrendering control over their public health agencies is inconsistent with the guarantee to every state of a republican form of government set forth in Article IV, §4 of the Constitution and with fundamental principles of federalism.

STATUTES INVOLVED

The National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat 2226, 42 U.S.C. §300k *et seq.*, is set forth in Appendix C to this Statement.

STATEMENT

This case presents issues of enormous public significance which were explicitly left unresolved in *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n.17 (1976). It also presents related issues bearing directly on the role of the States in our federal system of government with respect to which the Court has previously granted plenary review. *See Brown* v. *Environmental Protection Agency*, 521 F.2d 827 (9th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Appellants, including the State of North Carolina and the State of Nebraska, challenge the constitutionality of the National Health Planning and Resources Development Act of 1974 ("the Act" or "the Health Planning Act"). The Act provides for unprecedented federal government intrusion into, and control over, state legislative and administrative functions in the field of public health. In particular, the Act

requires Appellant North Carolina to amend its constitution, upon penalty of forfeiting all federal funding for approximately fifty public health programs which are critical to the health and welfare of its citizens and which have existed for many years prior to enactment of the Health Planning Act.

The Health Planning Act requires each state to establish a State Health Planning and Development Agency, or "State Agency," which must be designated by the state as the sole state agency with overall responsibility for and legally enforceable control over the planning and development of health care resources—regardless of the roles previously played by pre-existing state regulatory mechanisms. 42 U.S.C. §300m-1(b)(1). The State Agency must implement state health plans under the Act, under §1122 of the Social Security Act, 42 U.S.C. §1320a-1, and under pre-existing and prospective state law. 42 U.S.C. §300m-2(a). It is also required to approve all contracts and grants for the planning and development of health resources on the basis of approved priorities, to review no less than every five years all institutional health services being offered in the state, and to establish a state medical facilities plan. 42 U.S.C. §§300m–300m-2, 300o-2.

Most significantly, each state must adopt a certificate of need statute, satisfactory to the Secretary of Health, Education, and Welfare, under which no health care service, facility, or organization, whether public or private, may be built, equipped, expanded, or modernized without a certificate of need, 42 U.S.C. §300m-2(a)(4)(B). Under this drastic, unprecedented provision, a clinic or hospital which receives *no governmental aid whatsoever* can neither expand nor modernize its facilities unless it receives a certificate of need from a regulatory agency created pursuant to the Act. *Id.* A local community or even a group of private citizens which decides

that a particular medical facility is essential and which is willing to use solely private funds to construct that facility cannot do so unless the agency established pursuant to the Act decides that such a facility is needed. The Supreme Court of North Carolina has unanimously held that legislation establishing such a certificate of need system violates the Constitution of North Carolina. *In re Certificate of Need for Aston Park Hospital, Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973).

At the heart of the Act are the sanctions imposed if a state fails to comply with any of the requirements of the Act. Not only is a non-complying state denied funding under the Act, but in addition, under 42 U.S.C. §300m(d), neither the state nor any agency or resident thereof can receive any allotment, grant, loan, or loan guarantee or enter into any contract under three previously enacted statutes, the Public Health Service Act, 42 U.S.C. §201 *et seq.*, the Community Mental Health Centers Act, 42 U.S.C. §2681 *et seq.*, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 U.S.C. §4541 *et seq.*, encompassing at least fifty long-standing programs essential to the health of the state's citizens. Appendix D contains a partial listing of some such programs of particular importance to appellants.

None of these programs are created by the Health Planning Act. To the contrary, they have existed for many years, have been jointly funded by state and federal monies, and bear no direct relationship to the Health Planning Act. Nevertheless, that Act requires a state to enact certain legislation or lose all federal funding for all such programs, including funding for venereal disease prevention and control; student loans; diagnosis, treatment, and control of sickle cell anemia; family planning programs; family health service clinics for domestic agricultural migrants; and treatment,

training, and research in the field of mental health. The estimated annual monetary loss (in 1975 dollars) to Appellant State of North Carolina will be nearly fifty million dollars; that to Appellant State of Nebraska will be over seventeen million dollars. The human costs are incalculable.

Economic coercion of this magnitude by Congress is virtually irresistible, and most states will be constrained to surrender their sovereignty and enact the legislation dictated by Congress. Appellant North Carolina faces a constitutional dilemma of even greater proportions because the legislation required by Congress violates the Constitution of North Carolina. North Carolina must therefore amend its constitution or forfeit all such funding. Appellants ask the Court to review and reverse the decision of the United States District Court for the Eastern District of North Carolina upholding such unprecedented use of the Congressional spending power to strip states of their sovereignty.

THE QUESTIONS ARE SUBSTANTIAL

1. The Spending Power Is Not So Broad That The Federal Government May Coerce States Into Enacting Legislation Against Their Will And Surrendering Their Control Over Essential Governmental Functions.

This case raises the issue which was explicitly left unresolved by the Court in *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n.17 (1976): Whether there are limits on the extent to which Congress may use its spending power granted by Art. I, §8 of the United States Constitution to accomplish indirectly a result which it cannot attain directly under the Commerce Clause and which is contrary to the Tenth Amendment and fundamental principles of federalism.

National League of Cities, supra, clearly indicates that Congress cannot under the Commerce Clause directly order

a state to enact legislation, in matters of traditional local governmental concern, which is contrary to the sovereign will of the state. Nor can there be any question that Congress may not utilize the Commerce Clause to require a state to amend its constitution. In the Health Planning Act, Congress has sought to accomplish the same result indirectly, by tying the continuation of funding under essential pre-existing programs to the enactment of specified state legislation. If such Congressional action is constitutionally permissible, then the principles of federalism underpinning *National League of Cities* will have little continuing vitality, for Congress will be able to intrude upon state sovereignty to whatever extent it desires simply by terminating or threatening to terminate critical federal funding to a state unless the state yields to Congressional commands. Appellants respectfully submit, therefore, that it is now essential for the Court to resolve the issue left open in *National League of Cities*, and define the limits upon use of the spending power to wrest from states control over those functions which are essential to their separate and independent existence as coordinate elements in our federal system.

Appellants recognize that Congress may utilize its spending power to induce states to cooperate on matters of national concern. The spending power is not, however, limitless. In order to define the permissible scope of the power, courts must assess whether the challenged Congressional action coerces the states or merely induces them to act, *see, e.g., Steward Machine Co.* v. *Davis*, 301 U.S. 548 (1937); *Vermont* v. *Brinegar*, 379 F. Supp. 606, 616 (D. Vt. 1974); the relationship, if any, between the challenged Congressional action and the federal spending that is threatened to be terminated as well as the ability of the states themselves to regulate the matter sought to be regulated by Congress, *see Steward Machine Co.* v. *Davis, supra; Vermont* v. *Brinegar, supra*; and whether Congress could accomplish its regulatory

aim by means of a less drastic interference with state sovereignty, *see National League of Cities, supra*, at 853. *See also* discussion of the scope of the commerce power in *District of Columbia* v. *Train*, 521 F.2d 971, 994 (D.C. Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Under this analysis, the Health Planning Act fails to pass Constitutional muster. First, the Act's threatened withdrawal of benefits under pre-existing health care programs so drastically impairs the ability of the states to continue to perform one of their most important governmental functions, protection of the public health, that it constitutes coercion rather than inducement. A state has no practical alternative but to yield to the dictates of Congress because withdrawal of such funding would result in the breakdown of the entire health care system of the state. Neither North Carolina nor Nebraska can expose its citizens to such drastic sanctions. If such a threat of a complete curtailment of federal funding under approximately fifty pre-existing federal health care programs does not constitute an invalid penalty rather than a permissible inducement, as the District Court held, then clearly nothing short of complete termination of all federal funds whatsoever would constitute coercion. Such a limitation would, in effect, be no limitation whatsoever on the power of Congress to dictate to the states on virtually any subject, and would undercut completely the rule of *National League of Cities*. *See also Oregon* v. *Mitchell*, 400 U.S. 112, 126 (1970).

Second, the public health traditionally has been recognized as an area of particular state and local concern which individual states are fully capable of regulating.[2] Indeed, the

[2] *See National League of Cities* v. *Usery*, 426 U.S. 833, 851 (1976); *Barsky* v. *Board of Regents*, 347 U.S. 442, 449 (1954); and *Linder* v. *United States*, 268 U.S. 5, 17 (1925).

states are better suited to assess the particular needs of their citizens and the resources of their health care institutions.

Third, the penalty prescribed by the Health Planning Act bears little if any relationship to the regulatory objectives of the Act. The Act does not threaten to withhold new federal funding. Nor does it threaten to terminate only funding for health planning activities. Instead, it requires forfeiture of all federal funding for fifty unrelated and previously existing programs. Moreover, the Act seeks to regulate programs and activities which receive no federal funds whatsoever. It is one thing for Congress to condition the grant of a federal benefit on reasonable, narrow terms governing the use and provision of such benefit. It is quite another thing for Congress to arrogate to the federal government matters of traditional local control by threatening to terminate unrelated benefits which have been granted to, and relied upon by, the states for many years.[3]

Finally, there are less drastic methods of dealing with health cost control than requiring a state to amend its consti-

[3] In the context of federal regulation of academic institutions, Kingman Brewster, Jr. has said:

> "It is not sufficient to say that since the government is paying the bills, therefore it has a right to specify the product. This would be understandable if all that is being offered were special support for the program of special federal interest. To say, however, that support for all general educational activities of national importance will be withheld unless a school enlarges the program the government is particularly interested in, is to use the threat of cutting off aid for one purpose in order to accomplish another."

[Address to the Fellows of the American Bar Foundation, reprinted in *Yale Medicine*, Vol. 10 (Spring 1975) at 4.]. This observation is even more forceful when the object of federal regulation is not a private organization but a coordinate, sovereign element of our system of government.

tution and transform health care into a federally regulated public utility.[4] The court below did not consider obviously less drastic[4] alternatives because that court erroneously regarded the Congressional spending power as limitless.

2. The Guaranty Clause Forbids Federal Usurpation Of State Government Functions.

The Health Planning Act also contravenes the Guaranty Clause of Article IV, §4 in three respects. First, by requiring enactment by states of specified legislation and by granting to the federal government authority to approve or disapprove of the allocation of state resources to the State Agencies, it separates the spending power of the states from their taxing power and actually deprives the citizens of North Carolina and Nebraska of a substantial measure of control over the amount and manner of state expenditures. The Court has previously announced its intention to review this important issue, but the cases in question were instead vacated as moot following withdrawal of the federal regulatory action at issue. *Brown* v. *Environmental Protection Agency*, 521 F.2d 827, 840 (9th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977); *Maryland* v. *Environmental Protection Agency*, 530 F.2d 215 (4th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 97 S.Ct. 1635 (1977).

Second, by coercing states to enact legislation and allocate resources against their will, the Act deprives citizens of such states of their self-determination. This problem is most dramatically illustrated by the dilemma in which North Carolina finds itself: Under the Act, it must either suffer the

[4] *See, e.g.*, Section 1122 of the Social Security Act, 42 U.S.C. §1320a-1, which pertains only to the provision of federal monies and does not regulate private medical activities.

collapse of its public health system for lack of federal funding or it must amend its constitution.

Third, the Health Planning Act subverts the independence of state government by effectively transforming state officials into agents of the federal government whose every action is controlled by federal administrators. The Act subjects state agencies to pervasive federal controls not only when the agencies administer federal programs but in every aspect of public health planning, regardless of the relationship of that planning to any federal concern or activity. Under the Act, any state agency which conducts health planning activities is subject to complete federal control. 42 U.S.C. §§300m-2(a)(1), 300m-1(b)(1) and 300m-1(b)(4–6).

The court below gave scant consideration to these arguments and essentially relied on the erroneously oversimplified view that since the federal government is providing funding, the federal government is entitled to determine the manner in which the funds are dispensed. Appendix A at a-5. There are at least three conspicuous flaws in this analysis. In the first place, as discussed *supra* at 4–5, the Health Planning Act seeks to extend federal control to all health care facilities regardless of whether they receive any federal funding. Second, even when federal funding is at issue, it is not merely the federal government that provides the funds. The projects are joint with states such as North Carolina and Nebraska, expending state monies as well. Finally, the penalty provided by the Act pertains to preexisting programs for which funds have already been spent and with respect to which a state does not have the same ability to refuse to participate as would be the case if the programs had never been initiated. Appellants respectfully submit that there must be some limit on the ability of Congress to fund programs jointly with the states, to induce reliance of the citizenry, particu-

larly the old and the infirm, on such programs and then to use the threat of termination of such programs to seize effective control of taxing and spending powers of states which are otherwise protected by the Guaranty Clause.

> As the Court noted in *In re Duncan*, 139 U.S. 449 (1891):
>
> "By the Constitution, a republican form of government is guaranteed to every State in the Union, and the distinguishing feature of that form is the right of the people to choose their own officers for governmental administration, and pass their own laws in virtue of the legislative power reposed in representative bodies, whose legitimate acts may be said to be those of the people themselves . . . ." *Id.* at 461.

The Health Planning Act reduces that right to an empty formality by requiring states to enact legislation prescribed by the federal government and to cede to the Secretary control over the budgets and performance of state health care agencies. It has been recognized in recent years, however, that the Guaranty Clause, like the Tenth Amendment, is not a mere formality but instead an important safeguard of rights within a federal system and that the clause is judicially enforceable. See *Kohler* v. *Tugwell*, 292 F. Supp. 978, 984–5 (E.D. La. 1968) (Three-Judge Court), *aff'd*, 393 U.S. 531 (1969). Thus, the Court should hold the Health Planning Act invalid as repugnant to the Guaranty Clause.

CONCLUSION

As Mr. Justice Rehnquist noted in *Fry* v. *United States*, 421 U.S. 542, 559 (1975):

> "Surely there can be no more fundamental constitutional question than that of the intention of the Framers of the Constitution as to how authority should be allocated between the National and State Governments."

Moreover, the questions presented by this case transcend even principles of federalism, for the permissible scope of the spending power affects not only powers reserved to the states but also rights of individual citizens.

Appellants, who include two states of the United States, have raised a fundamental constitutional question—a question explicitly left open by the Court only two years ago. The decision below dealt with this important question in an extremely abbreviated fashion, and appellants respectfully suggest that summarily to affirm that decision could well inhibit the careful and orderly development of extraordinarily significant constitutional principles.[5]

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[5] *See Colorado Springs Amusements, Ltd.* v. *Rizzo*, 428 U.S. 913 (Opinion of Mr. Justice Brennan). *See generally* Note, *Summary Disposition of Supreme Court Appeals*, 52 B.U. L. Rev. 373 (1972).

The scope of the Spending Power is perhaps the most important constitutional subject of this generation. Appellants respectfully submit that issues of this magnitude require plenary review.

Respectfully submitted,

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APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
RALEIGH DIVISION

No. 76-0049-Civ-5

STATE OF NORTH CAROLINA EX REL SARAH T. MORROW, Secretary of the North Carolina Department of Human Resources,
Plaintiff,
AMERICAN MEDICAL ASSOCIATION and NORTH CAROLINA MEDICAL SOCIETY,
Plaintiffs-Intervenors,
STATE OF NEBRASKA,
Plaintiff-Intervenor,
—VERSUS—
JOSEPH A. CALIFANO, Secretary of the United States Department of Health, Education and Welfare,
Defendant,
AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC.,
Defendant-Intervenor,
NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS,
Defendant-Intervenor.

(Filed September 22, 1977)

OPINION and ORDER

Heard: July 6, 1977 Decided: September 22, 1977

THREE-JUDGE COURT: RUSSELL, Circuit Judge, LARKINS, Chief District Judge, and DUPREE, District Judge.

This is a suit against the Secretary of Health, Education and Welfare challenging the constitutionality of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. 300k *et seq.* (hereinafter referred to as "the Act"). The original complainant was the State of North Carolina. Later, interventions by the American Medical Association, the North Carolina Medical Society, as well as by the State of Nebraska, were allowed.

The attack by North Carolina on the Act focuses primarily on the requirement thereunder that any State, in order to qualify for financial grants under the federal health programs, should establish a State Health Planning and Development Agency, which, among other things, should "administer a State certificate of need program [satisfactory to the Secretary] which applies to new institutional health services proposed to be offered or developed within the State" and under which "only those services, facilities, and organizations found to be needed shall be offered or developed in the State."[1] And the reason for the State's concern is found in the decision of its own Supreme Court that a certificate of need statute as required under the Act "is in excess of the constitutional power of the Legislature." *In Re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S. E. 2d 729, 733 (1973). Absent a constitutional amendment, the State argues it would be required by the challenged provision of the Act to forfeit its right to participate in some forty-odd federal financial assistance health programs. It contends that, under these circumstances, the requirement represents an effort to compel the State to amend its constitution and thus constitutes an unconstitutional interference with the State's legislative and constitutional processes violative of the principles of federalism and state sovereignty, as guaranteed under the due process clause, the Tenth Amendment and the Guaranty Clause of Article IV, Section 4 of the Constitution.

[1] 42 U.S.C. §300m-2(a)(4)(B).

The American and North Carolina Medical Associations, who have intervened in support of the plaintiff North Carolina, join in the grounds raised by North Carolina against the validity of the certificate of need requirement. In addition, they argue that the Act is invalid because it seeks to convert private facilities into public facilities subject to federal regulation and "interferes with the physician-patient relationship by rationing health resources for reasons unrelated to the promotion of high quality care." They rely, as authority for their special contentions, on the First, Fifth and Ninth Amendments.

The intervenor Nebraska, which similarly supports the position of North Carolina, also asserts an independent ground of attack on the Act. It would find invalid on constitutional grounds the population requirements for health service areas established under the Act and the related waiver provisions.

The defendant, in his answer, denies the validity of the contentions of the plaintiff and its supporting intervenors. As is obvious, there are no real issues of contested fact; the dispositive issues are legal. All parties have recognized this and both sides have moved for summary judgment. Under these circumstances, disposition of the cause on the basis of such motions is appropriate.

As we have said, the primary attack of the plaintiff North Carolina relates to the certificate of need requirement in the Act. In making such an attack, the plaintiff concedes

that, in the exercise of a valid spending power, the federal government may impose terms and conditions upon fiscal grants allotted by it among the States. *King v. Smith* (1968) 392 U. S. 309; *Oklahoma v. Civil Service Comm'n.* (1947) 330 U. S. 127. Nor does the plaintiff dispute the validity of federal appropriations to promote the public health under the general welfare clause. Its attack on the certificate of need requirement is that, while Congress may attach conditions to federal grants to the states, such conditions may not be arbitrary, may not be unrelated to the legitimate purposes of federal health legislation, and may not invade the sovereign rights of the states.

The Act as a whole had as one of its basic purposes the more efficient and economical uses of health services. It grew out of a Congressional concern that the many unneeded hospital beds available in the nation imposed an unnecessarily exorbitant financial burden on the furnishing of required health care, and that there was an uneven distribution of health care facilities, resulting in some areas being over supplied and others being woefully deficient.[2] It sought through a national health planning policy to provide for the development of a program for dealing with the "maldistribution of health care facilities and manpower" and to "authorize financial assistance for the development of resources to further that policy."[3] An integral part of such a program was the certificate of need requirement which the plaintiff assails. The State health planning and development agency, authorized under the Act, was to "[s]erve as the designated planning agency of the State [to] *** (B) administer a State certificate of need program which [should apply] to new institutional

[2] *See U.S. Code Congr. & Admn. News*, 93rd Cong., 2d Sess., 1974, pp. 7878-9.

[3] 42 U.S.C. 300k(a) (B) and (b).

health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed ***, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State."[4]

We perceive nothing unconstitutional either in the purposes of the Act or in the condition thereby attached to health grants made to the States under federal health programs. Without question Congress in making grants for health care to the States, should be vitally concerned with the efficient use of the funds it appropriated for that purpose. It had a perfect right to see that such funds did not cause unnecessary inflation in the cost of health costs to the individual patient. It certainly had the power to attach to its grants conditions designed to accomplish that end.

The plaintiff argues, however, that however valid such power may be generally, this power of the federal government to attach conditions to grants to the States is not an unlimited one and may not be stretched to validate "coercive" conditions; and that it urges is the necessary consequences of the requirement of a State certificate of need law. In support of this argument, it relies primarily on *Steward Machine Co. v. Davis* (1937) 301 U. S. 548. In *Steward*, the Court recognized that to hold "motive or temptation [on the part of a State to comply with a condition attached to a federal appropriation grant] is [to be construed as] equivalent to coercion is to plunge the law in endless difficulty."[5] It accordingly declared as a general rule, that whenever the condition attached by Congress to an appropriation

[4] 42 U.S.C. § 300m-2(a)(4)(A)(B).

[5] 301 U. S. at 589–590.

grant available to the States relates to a "legitimately national" purpose, inducement or temptation to conform[6] does not go beyond the bounds of the federal government's legitimate spending power and is not coercion in any constitutional sense.[7]

It is not to be assumed that the plaintiff would argue that fiscal support for a national health program is not a legitimate national interest, which will support a federal grant to the States. Were it to do so, it would undercut the very basis of its action, which seeks to secure the benefits of such grants without compliance with the challenged condition. Accepting then the premise that such federal support is constitutionally valid, it would seem manifest that the federal government could validly attach a condition which was intended to assure the efficient use of the funds so granted. Such a condition would certainly relate to the legitimate national interest in health. So viewed, it would satisfy the standard phrased by Justice Cardozo in *Steward* and would be no more onerous on States than countless other federal programs in other fields, such as highways, etc.

The plaintiff, North Carolina, would, however, find the condition coercive under the unique circumstances applicable to it. This situation arises because the Supreme Court of North Carolina, by declaring that the Constitution of North Carolina, as it presently exists, proscribes the creation and operation of a state certificate of need mechanism.[8] As a

[6]In our recent opinion in *State of Maryland v. Environmental Protection Ag.* (4th Cir. 1975) 530 F. 2d 215 at 229, *vacated and remanded* 429 U. S. 1036, we spoke of these inducements as "[t]he alternative whip of economic pressure and seductive favor," which are legitimate under the constitutional spending power.

[7]301 U. S. at 591.

[8]*In Re Certificate of Need for Aston Park Hosp., Inc., supra,* 282 N. C. 542, 193 S. E. 2d 729 (1973).

result of that ruling North Carolina is threatened with a future loss of federal aid under some forty-two federal health assistance programs, a loss which can only be avoided by a constitutional amendment. When a legislative condition operates that drastically upon a State, the plaintiff contends, it becomes "coercive," and not simply inducement. It is unfortunate that its Constitution, as presently phrased and interpreted, might prevent compliance by North Carolina with the federally established condition. Simply because one State, by some oddity of its Constitution may be prohibited from compliance is not sufficient ground, though, to invalidate a condition which is legitimately related to a national interest sought to be achieved by a federal appropriation and which does not operate adversely to the rights of the other States to comply. Were this not so, any State, dissatisfied by some valid federal condition on a federal grant could thwart the congressional purpose by the expedient of amending its Constitution or by securing a decision of its own Supreme Court. The validity of the power of the federal government under the Constitution to impose a condition on federal grants made under a proper Constitutional power does not exist at the mercy of the State Constitutions or decisions of State Courts. Moreover, the "coercive" effect of a termination of federal assistance on the plaintiff North Carolina seems quite unreal. The actual loss to North Carolina should it lose all federal assistance health grants would be less than fifty million dollars; in 1974, its State revenues totalled some 3.1 billion dollars. The impact of such loss could hardly be described as "catastrophic" or "coercive."

It must be remembered that this Act is not compulsory on the State. Unlike the legislation faulted in *State of Maryland v. Environmental Protection Ag., supra,* 530 F. 2d 215, it does not impose a mandatory requirement to enact legislation on the State; it gives to the states an *option* to enact such

legislation and, in order to induce that enactment, offers financial assistance.[9] Such legislation conforms to the pattern generally of federal grants to the states and is not "coercive" in the constitutional sense.

It is true that the assailed condition contemplates that the state certificate of need program will apply to all health facilities constructed or expanded in the State. It will therefore cover the construction of new, or the expansion of existing health facilities, whether publicly or *privately* owned and financed. It is obvious, though, that, if only public construction were covered by the certificate of need program, the public interest in avoiding unnecessary increases in health care by reason of the addition of unneeded additional facilities could be thwarted by private construction. For this reason, every court which has considered the constitutional validity of state certificate of need laws has found that the inclusion of private construction within the law's coverage valid and reasonable, save in the North Carolina case already cited. *See, Simon v. Cameron* (C.D.Cal. 1970) 337 F. Supp. 1380; *Attoman v. Department of Social Welfare* (1966) 270 N.Y.S. 2d 167, 27 A.D.2d 12; *Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty* (1974) (N.J. App.) 330 A. 2d 370. We find the reasoning of these cases sound, as applied to this Act.

We find equally unpersuasive that this Act, with its certificate of need condition, threatens "the integrity of a recognized state government" and the "Republican form of government" and is therefore violative of the Guaranty Clause of the Constitution, Article IV, Section 4, or the Tenth Amendment. As we have already observed, the statutory condition on which the plaintiff directs its attack is not

[9]*Massachusetts v. Mellon* (1923) 262 U. S. 447, 480.

mandatory but is to be adopted or not at the option of the State and its burden on the State, if it should operate to terminate the plaintiff's right to participate under the federal health assistance programs, would not be coercive.[10]

The Medical Associations would fault the Act as an unlawful invasion of the patient-doctor relationship. We have carefully reviewed the Act and we find no basis for such claim. It follows that the challenge of the plaintiff North Carolina and the intervenors Medical Associations to the Act fails.

It remains to consider the special attack of the intervenor Nebraska on that provision of the Act which directs that each health service area under the Act contain a population of at least 500,000, except in "unusual" or "highly unusual" circumstances, to be determined by the Secretary. It urges that such a classification has no rational relationship to "the stated priorities of said Act." The legislative history indicates that Congress concluded that any effective planning of health care required as a necessary operating predicate "an adequate base of population and health resources" and, to achieve such a "base" it arrived at the population stan-

[10]Plaintiff cites *National League of Cities v. Usery* (1976) U.S. , 44 U.S.L.W. 4974. That case is not in point. It involved whether the Commerce Clause authorized a wage-hour amendment covering the employees of states or their subdivisions. We do not have such a direct regulation here; neither is the constitutional basis for the condition the Commerce Clause. The constitutional authorization in this case is the "spending power." *See* Note, *Applying the Equal Pay Act to State and Local Governments: The Effect of National League of Cities v. Usery*, 125 *U. Pa. L. Rev.* 665 at 676. In *Usery*, the Court was careful to point out that it was not considering the validity of the federal legislation under that power. The limited application of *Usery* was recognized in *Usery v. Charleston County School District* (4th Cir. 1977) F. 2d .

dard stated in the Act. We are unable to say that such legislative determination was arbitrary or irrational. Neither do the exemptions or waivers allowable for "unusual" circumstances fall under any constitutional interdict. The Congress in so providing, recognized that there might be areas in the nation where some variation from the population pattern would be justified "to overcome travel time, geographic and/or economic barriers to receipt of health services in non-metropolitan areas." This would appear a reasonable provision.

Accordingly, the motion of the defendant for summary judgment is granted.

AND IT IS SO ORDERED.

/s/ DONALD RUSSELL
U. S. Circuit Judge

/s/ JOHN D. LARKINS, JR.
Chief U. S. District Judge

/s/ FRANKLIN T. DUPREE, JR.
U. S. District Judge

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
RALEIGH DIVISION

STATE OF NORTH CAROLINA EX REL SARAH T. MORROW, Secretary of the North Carolina Department of Human Resources, *Plaintiff*, AMERICAN MEDICAL ASSOCIATION and NORTH CAROLINA MEDICAL SOCIETY, *Plaintiff-Intervenors*, STATE OF NEBRASKA, *Plaintiff-Intervenor*, —VERSUS— JOSEPH A. CALIFANO, Secretary of the United States Department of Health, Education and Welfare, *Defendant*, AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC., *Defendant-Intervenor*, NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS, *Defendant-Intervenor*.	CIVIL ACTION NO. 76-0049-CIV-5

(Filed November 9, 1977)

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that the plaintiff State of North Carolina ex rel Sarah T. Morrow and plaintiff-intervenors

American Medical Association, North Carolina Medical Society and the State of Nebraska hereby appeal to the Supreme Court of the United States from the final judgment allowing the motion of the defendant for summary judgment and dismissing the action herein on September 30, 1977.

This appeal is taken pursuant to 28 U.S.C. 1253.

Respectfully submitted,

For the State of North Carolina:

/s/ WILLIAM F. O'CONNELL

Rufus L. Edmisten, *Attorney General*

William F. O'Connell, *Special Deputy Attorney General*

Robert R. Reilly, *Assistant Attorney General*

NORTH CAROLINA DEPARTMENT OF JUSTICE
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For the American Medical Association and North Carolina Medical Society:

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For the State of Nebraska:

/s/ MEL KAMMERLOHR

Mel Kammerlohr
Assistant Attorney General
2115 State Capitol
Lincoln, Nebraska 68509

Date: 9th November, 1977

PROOF OF SERVICE

I, William F. O'Connell, attorney for plaintiff State of North Carolina ex rel Sarah T. Morrow, appellant herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that, on the 9th day of November, 1977, I served copies of the foregoing Notice of Appeal to the Supreme Court of the United States on the parties required to be served by placing said documents in envelopes with first class postage affixed and by depositing said envelopes in the United States Post Office in Raleigh, North Carolina, said envelopes being addressed as follows:

Solicitor General
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Washington, D.C. 20530

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All parties required to be served have been served.

/s/ William F. O'Connell

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APPENDIX C

The National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 226, 42 U.S.C. §300k *et seq.* provides in pertinent part as follows:

§300k. *Congressional findings*

(a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services.

(b) In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

§300k-1. *Regulations prescribing guidelines*

(a) The Secretary shall, within eighteen months after January 4, 1975, by regulation issue guidelines concerning national health planning policy and shall, as he deems appropriate, by regulation revise such guidelines. Regulations under this subsection shall be promulgated in accordance with section 553 of Title 5.

(b) The Secretary shall include in the guidelines issued under subsection (a) of this section the following:

(1) Standards respecting the appropriate supply, distribution, and organization of health resources.

(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 300k–2 of this title, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

(c) In issuing guidelines under subsection (a) of this section the Secretary shall consult with and solicit recommendations and comments from the health systems agencies designated under part B of this subchapter, the State health planning and development agencies designated under part C of this subchapter, the Statewide Health Coordinating Councils established under part C of this subchapter, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 300k–3 of this title.

§300k–2. *National health priorities*

The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

§300*l*. *Health service areas*

(a) There shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 300*l*–4 of this title. Each health service area shall meet the following requirements:

(1) The area shall be a geographic region appropriate for the effective planning and development of health services determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) the population of an area may—

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than—

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary),

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1320c–1 of this title for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas.

The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other

requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

(b)(1) Within thirty days following January 4, 1975, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

(A) A statement of the requirement (in subsection (a) of this section) of the establishment of health service areas throughout the United States.

(B) A statement of the criteria prescribed by subsection (a) of this section for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of January 4, 1975, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 246(a) of this title, each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 246(b) of this title, and each regional medical program established in the State under subchapter VII of this chapter.

(3)(A) Within two hundred and ten days after January 4, 1975, the Secretary shall publish as a notice in the Federal Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

(B)(i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a) of this section, he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary, in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) of this section for the establishment of health service areas throughout the United States.

(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that a boundary for a health service area no longer meets the requirements of subsection (a) of this section, he may revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B of this subchapter and the appropriate Statewide Health Coordinating Council established under part C of this subchapter. A request for boundary revision shall be made only after consultation with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.

(5) Within one year after January 4, 1975, the Secretary shall complete the procedures for the initial establishment of the boundaries of health service areas which (except as provided in section 300n–5 of this title) include the geographic area of all the States.

(c) Notwithstanding any other requirement of this section, an area—

(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 246(b) of this title, and

(2) which otherwise meets the requirements of subsection (a) of this section,

shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.

§300*l*–1. *Health systems agency*

(a) For purposes of this subchapter, the term "health systems agency" means an entity which is organized and operated in the manner described in sub-

section (b) of this section and which is capable, as determined by the Secretary, of performing each of the functions described in section 300*l*–2 of this title. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) of this section and section 300*l*–2 of this title.

(b)(1) A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before January 4, 1975) to carry out health planning and review functions such as those described in section 300*l*–2 of this title, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

(2) Staff.

(A) A health systems agency shall have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii) health planning, and (iv) development and use of health resources. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function.

(B) The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

(3) Governing body.

(A) A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with subparagraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in section 300*l*–2 of this title.

Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C), of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

(B) The governing body—

(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria (developed and published pursuant to section 300n–1 of this title) applicable to its functions under subsections (e), (f), and (g) of section 300*l*–2 of this title;

(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 300*l*–2(b) of this title;

(iii) shall be responsible for the approval of grants and contracts made and entered into under section 300*l*–2(c)(3) of this title;

(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), (g), and (h), of section 300*l*–2 of this title;

(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health systems plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

(vi) shall reimburse its members for their reasonable costs incurred in attending meetings of the governing body;

(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

(viii) shall (I) conduct its business meetings in public, (II) give adequate notice to the public of such meetings, and (III) make its records and data available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall be not less than one-half of its members.

(C) The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

(i) A majority (but not more than 60 per centum of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor within the twelve months preceding appointment been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

(ii) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, optometrists, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, substance abuse treatment facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 300n(3)) of this title.

(iii) The membership shall—

(I) Include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health,

(II) include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and

(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 300e–9 of this title), include at least one member who is representative of such organizations.

(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph.

(4) No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this subchapter, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

(5) No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of Title 26 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees.

(6) Each health system agency shall—

(A) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(B) provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter and section 300t of this title; and

(C) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this subchapter and section 300t of this title.

(c) A health systems agency may establish subarea advisory councils representing parts of the agencies' health service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C) of this section.

§300*l*–2. *Functions of health systems agencies*

(a) For the purpose of—

(1) improving the health of residents of a health service area,

(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services, and

(4) preventing unnecessary duplication of health resources,

each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through (g) of this section.

(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

(E) the patterns of utilization of the area's health resources, and

(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 242k(e) of this title.

(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 300k–1 of this title, the priorities set forth in section 300k–2 of this title, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this subchapter referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 300k–1 of this title respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this subchapter referred to as the "AIP") which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

(2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and

private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 300n–1(b) of this title.

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entitles to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 300t of this title. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.

(d) Each health systems agency shall coordinate its activities with—

(1) each Professional Standards Review Organization (designated under section 1320c–1 of this title),

(2) entities referred to in paragraphs (1) and (2) of section 3334(a) of this title and regional and local entities the views of which are required to be considered under regulations prescribed under section 4233 of this title to carry out section 4231(b) of this title,

(3) other appropriate general or special purpose regional planning or administrative agencies, and

(4) any other appropriate entity,

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this chapter, the Community Mental Health Centers Act, sections 409 and 410 of the Drug Abuse Office and Treatment Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources; or

(ii) made available by the State in which the health service area is located (from an allotment to the State under an Act referred to in clause (i))

for grants or contracts for the development, expansion, or support of health resources.

(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts under subchapter III, V, or VI of this chapter unless the grants or contracts are to be made, entered into or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian organization for any program or project which will be located within or will specifically serve—

(i) a federally-recognized Indian reservation,

(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

(iii) a Native village in Alaska (as defined in section 1602(c) of Title 43),

a health systems agency shall only review and comment on such proposed use.

(2) Notwithstanding any other provision of this chapter or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by such paragraph. If an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

(3) Each health systems agency shall provide each Indian tribe or intertribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m–2 (a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency.

(g) (1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 300m of this title for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 300*l*–4(c) of this title.

(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.

§300*l*–3. *Assistance to entities desiring to be designated as health systems agencies*

The Secretary may provide all necessary technical and other non-financial assistance (including the preparation of prototype plans of organization and operation) to nonprofit private entities (including entities presently receiving financial assistance under section 246 (b) of this title or subchapter VII of this chapter or as experimental health service delivery systems under section 242b of this title) which—

(1) express a desire to be designated as health systems agencies, and

(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 300*l*–1 and 300*l*–2 of this title,

to assist such entities in developing applications to be submitted to the Secretary under section 300*l*–4 of this title and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

§300*l*–4. *Designation of health systems agencies*

(a) At the earliest practicable date after the establishment under section 300*l* of this title of health service areas (but not later than eighteen months after January 4, 1975) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

(b) (1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to determining their ability to meet the requirements of section 300*l*–1(b) of this title, and their capacity to perform the functions prescribed by section 300*l*–2 of this title.

(2) During any period of conditional designation (which may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 300*l*–1(b) of this title and perform only such of the functions prescribed by section 300*l*–2 of this title as he determines such entity to be capable of meeting and performing. The number and type of such requirements and functions shall, during the period of conditional designation, be progressively increased as the entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection (c) of this section.

(3) Any agreement under which any entity is conditionally designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 300*l*–1(b) of this title and will be qualified to perform the functions prescribed by section 300*l*–2 of this title;

(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

In considering such applications, the Secretary shall give priority to an application which has been recommended for approval by each entity which has developed a plan referred to in section 246(b) of this title for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under subchapter VII of this chapter.

(c) (1) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) of this section as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 300*l*–1(b) and 300*l*–2 of this title and such conditions designed to carry out the purpose of this subchapter, as the Secretary may prescribe, and shall be for a term of not to exceed twelve months; except that, prior to the expiration of such term, such agreement may be terminated—

(A) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.

(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 300*l*–1(b) of this title and is qualified to perform or is performing the functions prescribed by section 300*l*–2 of this title. In considering such applications, the Secretary shall give priority

to an application which has been recommended for approval by (A) each entity which has developed a plan referred to in section 246(b) of this title for all or part of the health service area with respect to which the application was submitted, and (B) each regional medical program established in such area under subchapter VII of this chapter.

(3) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed twelve months if upon review (as provided in section 300n–4 of this title) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 300*l*–2 of this title and continues to meet the requirements of section 300*l*–1(b) of this title.

(d) If a designation under subsection (b) or (c) of this section of a health systems agency for a health services area is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b) or (c) of this section (as the Secretary determines appropriate), enter into a designation agreement with another entity to be the health systems agency for such area.

§300*l*–5. *Planning grants*

(a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 300*l*–4 of this title. A grant under this subsection shall be made on such conditions as the Secretary determines is appropriate, shall be used by a health systems agency for compensation of agency personnel, collection of data, planning, and the performance of the functions of the agency, and shall be available for obligation for a period not to exceed the period for which its designation agreement is entered into or renewed (as the case may be). A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources.

(b)(1) The amount of any grant under subsection (a) of this section to a health systems agency designated under section 300*l*–4(b) of this title shall be determined by the Secretary. The amount of any grant under subsection (a) of this section to any health systems agency designated under section 300*l*–4(c) of this title shall be the lesser of—

(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

(i) the amount determined under paragraph (1), and

(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

(B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) of this section which is computed on the basis of the formula prescribed by subparagraph (A) shall—

(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

(3) The amount of a grant under subsection (a) of this section to a health systems agency designated under section 300*l*–4(c) of this title may not be less than $175,000.

(c)(1) For the purpose of making payments pursuant to grants made under subsection (a) of this section, there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, and $125,000,000 for the fiscal year ending June 30, 1977.

(2) Notwithstanding subsection (b) of this section, if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) of this section as the total of the amounts appropriated under paragraph (1) for that fiscal year bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b) of this section; except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.

§300m. *Designation of State health planning and development agencies*

(a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m–2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b)(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by

section 300m–1 of this title and to carry out the State's health planning and development functions prescribed by section 300m–2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless—

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m–2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m–3 of this title.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) of this section may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m–2 of this title. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 300m–2 of this title as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3).

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated—

(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines

that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 300m–1 of this title.

(c) If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) of this section is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

(d) If, upon the expiration of the fourth fiscal year which begins after 1975, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this chapter, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.

§300m–1. *State administrative program*

(a) A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions prescribed by section 300m–2 of this title. The Secretary may not approve a State Program for a State unless it—

(1) meets the requirements of subsection (b) of this section;

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) The State Program of a State must—

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 300m–2 of this title and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with and authority for, the Statewide Health Coordinating Council (prescribed by section 300m–3 of this title), in carrying out such functions and the State Program;

(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 4728(a) of this title, but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 300n–1 of this title;

(6) require the State Agency to (A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

(7)(A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 242k(e) of this title of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this subchapter; and

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 300m–2(a) of this title or under subchapter XIV of this chapter which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 300*l*–2 of this title by a health systems agency within the State—

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency shall for purposes of this subchapter and subchapter XIV of this chapter be considered the decision of the State health planning and development agency.

(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b) of this section. The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

§300m–2. *State health planning and development functions*

(a) Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 300m–3 (c)(2) of this title) and the plans of the health systems agencies within the State which relate to the government of the State.

(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 300m–3(c) of this title.

(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 300*o*–2 of this title, and in the performance of its functions generally.

(4) (A) Serve as the designated planning agency of the State for the purposes of section 1320a–1 of this title if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be

offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 300*l*–2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*–2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 300*l*–2(g) of this title respecting the appropriateness of such services, make public its findings.

(b) (1) Any function described in subsection (a) of this section may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) of this section shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after January 4, 1975.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 300*l*–2(g) of this title with respect to the appropriateness of the service.

(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

§300m–3. *Statewide Health Coordinating Council*

(a) A State health planning and development agency designated under section 300*m* of this title shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the "SHCC") which (1) is organized in the manner described by subsection (b) of this section, and (2) performs the functions listed in subsection (c) of this section.

(b)(1) A SHCC of a State shall be composed in the following manner:

(A)(i) A SHCC shall have no fewer than sixteen representatives appointed by the Governor of the State from lists of at least five nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State.

(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC.

(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

(C) Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 300n(3) of this title).

(D) Where two or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

(2) The SHCC shall select from among its members a chairman.

(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

(c) A SHCC shall perform the following functions:

(1) Review annually and coordinate the HSP and AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 300n–4(c) of this title, its comments on such HSP and AIP.

(2)(A) Prepare and review and revise as necessary (but at least annually) a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs.

(B) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State agency under section 300m–2(a)(2) of this title, and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearing, and the place and period during which to direct written comment to the SHCC on the plan.

(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 300n–4(a) of this title, its comments on such budget.

(4) Review applications submitted by such health systems agencies for grants under sections 300*l*–5 and 300t of this title and report to the Secretary its comments on such applications.

(5) Advise the State Agency of the State generally on the performance of its functions.

(6) Review annually and approve or disapprove any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this chapter, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this chapter or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC disapproved such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

§300m–4. *Grants for State health planning and development*

(a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 300m of this title to assist them in meeting the costs of their operation. Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or renewed. The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 per centum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

(b) Grants under subsection (a) of this section shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satisfactory assurances that the State Agency will expend in performing the functions prescribed by section 300m–2 of this title during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

(c) For the purpose of making payments under grants under subsection (a) of this section, there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, and $35,000,000 for the fiscal year ending June 30, 1977.

§300m–5. *Grants for rate regulation—Limitation*

(a) For the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care, the Secretary may make to

a State Agency designated, under an agreement entered into under section 300m(b)(3) of this title, for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate (not later than six months after January 4, 1975) rates for the provision of health care within the State. Not more than six State Agencies may receive grants under this subsection.

(b) (1) A State Agency which receives a grant under subsection (a) of this section shall—

(A) provide the Secretary satisfactory evidence that the State Agency has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

(D) perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 300n–1 of this title;

(E) comply with the requirements prescribed by paragraphs (6) through (12) of section 300m–1(b) of this title with respect to the functions prescribed by subsection (a) of this section;

(F) provide for the establishment of a procedure under which the State Agency will obtain the recommendation of the appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

(G) meet such other requirements as the Secretary may prescribe.

(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which a State Agency shall perform its functions under a grant under subsection (a) of this section, including whether the State Agency should—

(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

(D) employ for each type or class of person engaged in the delivery of health services—

(i) a unit for determining the reimbursement rates, and

(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

(c) Grants under subsection (a) of this section shall be made on such terms and conditions as the Secretary may prescribe, except that (1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, and (2) no State Agency may receive more than three grants under subsection (a) of this section.

(d) Each State Agency which receives a grant under subsection (a) of this section shall report to the Secretary (in such form and manner as he shall prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a) of this section.

(e) There are authorized to be appropriated to make payments under grants under subsection (a) of this section, $4,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, and $6,000,000 for the fiscal year ending June 30, 1977.

§300n. *Definitions*

For purposes of this subchapter:

(1) The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(2) The term "Governor" means the chief executive officer of a State or his designee.

(3) The term "provider of health care" means an individual—

(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, substance abuse treatment facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

(B) who is an indirect provider of health care in that the individual—

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care.

(II) Entities engaged in the provision of health care or in such research or instruction.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

(IV) Entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

"(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(4) The term "health resources" includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(5) The term "institutional health services" means the health services provided through health care facilities and health maintenance organizations (as such facilities and organizations are defined in regulations prescribed under section 1320a–1 of this title) and includes the entities through which such services are provided.

§300n–1. *Procedures and criteria for review of proposed health system changes*

(a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 300*l*–2 of the title or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; and in performing its review functions under section 300m–2 of this title, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies and States Agencies may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) of this section at least the following:

(1) Written notification to affected persons of the beginning of a review.

(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made.

(3) Provision for persons subject to a review to submit to the agency or State Agency (in such form and manner as the agency or State Agency shall prescribe and publish) such information as the agency or State Agency may require concerning the subject of such review.

(4) Submission of applications (subject to review by a health systems agency or a State Agency) made under this chapter or other provisions of law for Federal financial assistance for health services to the health systems agency or State Agency at such time and in such manner as it may require.

(5) Submission of periodic reports by providers of health services and other persons subject to agency or State Agency review respecting the development of proposals subject to review.

(6) Provision for written findings which state the basis for any final decision or recommendation made by the agency or State Agency.

(7) Notification of providers of health services and other persons subject to agency or State Agency review of the status of the agency or State Agency review of the health services or proposals subject to review,

findings made in the course of such review, and other appropriate information respecting such review.

(8) Provision for public hearings in the course of agency or State Agency review if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting agency and State Agency decisions.

(9) Preparation and publication of regular reports by the agency and State Agency of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the agency and State Agency (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

(10) Access by the general public to all applications reviewed by the agency and State Agency and to all other written materials pertinent to any agency or State Agency review.

(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such detail as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

(c) Criteria required by subsection (a) of this section for health systems agency and State Agency review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under subchapter XI of this chapter.

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, and

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

The criteria established by any health systems agency or State Agency under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 300e–5(c) of this title.

§300n–2. *Technical assistance*

(a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions.

(b) The Secretary shall include in the materials provided under subsection (a) of this section the following:

(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

(B) Specification of the minimum data needed to determine the status of the health resources and services of a health service area.

(C) Specification of the minimum data needed to describe the use of health resources and services within a health service area.

(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 300k–1 of this title for appropriate planning and development of health resources, and which shall cover the priorities listed in section 300k–2 of this title.

(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for—

(A) the structure of a health systems agency, consistent with section 300*l*–1(b) of this title, and of a State Agency, consistent with section 300m–1 of this title;

(B) the conduct of the planning and development processes;

(C) the performance of health systems agency functions in accordance with section 300*l*–2 of this title; and

(D) the performance of State Agency functions in accordance with section 300m–2 of this title.

(c) In order to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology, the Secretary shall establish a national health planning information center to support the health planning and resources development programs of health systems agencies, State Agencies, and other entities concerned with health planning and resources development; to provide access to current information on health planning and resources development; and to provide information for use in the analysis of issues and problems related to health planning and resources development.

(d) The Secretary shall establish the following within one year of January 4, 1975:

(1) A uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions as defined by the Secretary in regulations. Such system shall provide for the calculation of the aggregate volume to be based on:

(A) The number of patient days;

(B) The number of patient admissions;

(C) The number of out-patient visits; and

(D) Other relevant factors as determined by the Secretary.

(2) A uniform system for cost accounting and calculating the volume of services provided by health services institutions. Such system shall:

(A) Include the establishment of specific cost centers and, where appropriate, subcost centers.

(B) Include the designation of an appropriate volume factor for each cost center.

(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions), and different sizes of such types of institutions.

(3) A uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions. Such system shall:

(A) Be based on an all-inclusive rate for various categories of patients (including, but not limited to individuals receiving medical, surgical, pediatric, obstetric, and psychiatric institutional health services).

(B) Provide that such rates reflect the true cost of providing services to each such category of patients. The system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health service institutions) and different sizes of such types of institutions.

(D) Provide that differences in rates to various classes of purchasers (including health insurers, direct service payors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers.

(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include—

(A) the number of beds operated by an institution;

(B) the geographic location of an institution;

(C) the operation of a postgraduate physician training program by an institution; and

(D) the complexity of services provided by an institution.

(5) A uniform system for the reporting by health services institutions of—

(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

(B) the costs and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions) and different sizes of such institutions.

§300n–3. *Centers for health planning*

(a) For the purposes of assisting the Secretary in carrying out this subchapter, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976.

(b)(1) No grant or contract may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in paragraph (2) and no grant or contract may be made under this section for operation of a center unless the center meets such requirements.

(2) The requirements referred to in paragraph (1) are as follows:

(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

(B) The staff of the center shall represent a diversity of relevant disciplines.

(C) Such additional requirements as the Secretary may by regulation prescribe.

(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies and State Agencies in performing their functions under section 300*l*–2 or 300m–2 of this title, respectively, and (2) shall use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies such planning approaches, methodologies,' policies and standards as they develop.

(d) For the purpose of making payments pursuant to grants and contracts under subsection (a) of this section there are authorized to be appropriated

$5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, and $10,000,000 for the fiscal year ending June 30, 1977.

§300n–4. *Review by the Secretary*

(a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 300m–3(c)(3) of this title. Information submitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress.

(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reporting system based on the performance standards that allows for continuous review of the structure, operation, and performance of the functions of such agencies.

(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality health care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 300*l*–1 (b) and 300*l*–2 of this title;

(3) the extent to which the agency's governing body (and executive committee (if any)) represents the residents of the health service area for which the agency is designated;

(4) the professional credentials and competence of the staff of the agency;

(5) the appropriateness of the data assembled pursuant to section 300*l*–2 (b) (1) of this title and the quality of the analyses of such data;

(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

(7) the extent to which it may be demonstrated that—

(A) the health of the residents in the agency's health service area has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

(C) increases in costs of the provision of health care have been restrained.

(d) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated State Agency to determine—

(1) the adequacy of the State health plan of the Statewide Health Coordinating Council prepared under section 300m–3(c)(2) of this title in

meeting the needs of the residents of the State for a healthful environment and for accessible, acceptable, and continuous quality health care at reasonable costs;

(2) if the structure, operation, and performance of the functions of the State Agency meet the requirements of sections 300m–1 and 300m–2 of this title;

(3) the extent to which the Statewide Health Coordinating Council has a membership meeting, and has performed in a manner consistent with the requirements of section 300m–3 of this title;

(4) the professional credentials and competence of the staff of the State Agency;

(5) the extent to which financial assistance provided under subchapter XIV of this chapter by the State Agency has been used in an effective manner to achieve the State's health plan under section 300m–3 (c) (2) of this title, and

(6) the extent to which it may be demonstrated that—

(A) the health of the residents of the State has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in the State has been improved; and

(C) increases in costs of the provision of health care have been restrained.

§300n–5. *Special provisions for certain states and territories*

(a) Any State which—

(1) has no county or municipal public health institution or department, and

(2) has, prior to January 4, 1975, maintained a health planning system which substantially complies with the purposes of this subchapter.

§300o–1. *Promulgation of regulations*

The Secretary shall by regulation—

(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 300o–2 of this title the priority among projects within the State for which assistance is available under this subchapter, based on the relative need of different areas within the State for such projects and giving special consideration—

(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid non-compliance with State or voluntary licensure or accreditation standards, and

(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(2) prescribe for medical facilities projects assisted under this subchapter general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

(3) prescribe criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

(5) require each State medical facilities plan under section 300k–3 of this title to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

(6) prescribe the general manner in which each entity which receives financial assistance under this subchapter or has received financial assistance under this subchapter or subchapter IV of this chapter shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

§300o–2. *State medical facilities plan*

(a) Before an application for assistance under this subchapter (other than part D) for a medical facility project described in section 300o of this title may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must—

(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this subchapter;

(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

(3) be approved by the Statewide Health Coordinating Council as consistent with the State health plan developed pursuant to section 300m–3(c)(2) of this title;

(4) set forth, in accordance with criteria established in regulations prescribed under section 300*o*–1(a) of this title and on the basis of a statewide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

(5) set forth a program for the State for assistance under this subchapter for projects described in section 300*o*, of this title which program shall indicate the type of assistance which should be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 300*o*–1(a) of this title;

(6) set forth (in accordance with regulations promulgated under section 300*o*–1(a) of this title) priorities for the provision of assistance under this subchapter for projects in the program set forth pursuant to paragraph (4);

(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this subchapter, and provide for enforcement of such standards;

(8) provide for affording to every applicant for assistance for a medical facilities project under this subchapter an opportunity for a hearing before the State Agency; and

(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) of this section if the State Agency, as determined under the review made under section 300n–4(d) of this title, is organized and operated in the manner prescribed by section 300m–1 of this title and is carrying out its functions under section 300m–2 of this title in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a) of this section, the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

APPENDIX D

Among the programs subject to termination pursuant to 42 U.S.C. §300m(d) if a state fails to comply with the requirements of the Health Planning Act are the following grants and other forms of funding under the Public Health Service Act, 42 U.S.C. §201 *et seq.*:

(1) Grants for the development of improved methods for the care, treatment, and rehabilitation of the mentally ill, and for the establishment and maintenance of traineeships in the field of mental health. 42 U.S.C. §242a.

(2) Grants to cover the cost of traineeships for graduate or specialized training in public health for physicians, engineers, nurses, sanitarians, and other professional health personnel. 42 U.S.C. §244–1.

(3) Grants for graduate public health training. 42 U.S.C. §245a.

(4) Grants for comprehensive public health services. 42 U.S.C. §246.

(5) Grants for communicable and other disease control programs. 42 U.S.C. §247b.

(6) Grants for venereal disease prevention and control programs. 42 U.S.C. §247b.

(7) Grants to establish and operate family health service clinics for domestic agricultural migrants. 42 U.S.C. §247d.

(8) Grants for the planning and development of community health centers. 42 U.S.C. §254c.

(9) Establishment of a regional branch of the National Library of Medicine. 42 U.S.C. §280a–1.

(10) Grants for training in medical library sciences, special medical library projects, and establishing, expanding, and improving medical libraries and related resources and establishment of regional medical libraries. 42 U.S.C. §§2806–4, 5, 7, 8.

(11) Grants and contractual agreements to support National Cancer Research and Demonstration Centers, and Cancer Control Programs. 42 U.S.C. §§286b, 286c.

(12) Grants for the establishment of prevention and control programs, research and demonstration centers, and research and training in diseases of the heart, blood vessels, lung and blood. 42 U.S.C. §§287a, 287c, 287d.

(13) Grants for the establishment of clinical traineeships in dental medicine. 42 U.S.C. §288a.

(14) Grants for research and training in the diagnosis, prevention, and treatment of diabetes and metabolic and digestive diseases. 42 U.S.C. §289c–1.

(15) Grants to establish research and training centers in the areas of diabetes and metabolic digestive diseases. 42 U.S.C. §289c–2.

(16) Grants for the establishment of arthritis screening, detection, and prevention programs, and the construction and operation of comprehensive arthritis centers. 42 U.S.C. §§289c–5, 6.

(17) Support in the development of comprehensive health, education, training, research, and planning programs for the prevention and treatment of mental illness and for the rehabilitation of the mentally ill. 42 U.S.C. §289k–1.

(18) Grants for biomedical and behavioral research in matters relating to the cause, diagnosis, prevention, and treatment of the diseases which concern the National Institute of Health and the Alcohol, Drug Abuse, and Mental Health Administration. 42 U.S.C. §289l–1.

(19) Grants for the establishment of specialized burn treatment centers. 42 U.S.C. §290a.

(20) Grants, loans, and loan guarantees for the construction and modernization of hospitals and other medical facilities. 42 U.S.C. §§291b, 291j–1.

(21) Grants for the construction or modernization of hospital emergency rooms. 42 U.S.C. §291j–9.

(22) Loan for the construction of experimental or demonstration hospital facilities. 42 U.S.C. §291m–1.

(23) Grants for the construction of health research facilities. 42 U.S.C. §292d.

(24) Grants and loan guarantees for the construction of teaching facilities for medical, dental, and other health personnel. 42 U.S.C. §§293a, 293i.

(25) Loan agreements for the establishment of student loan funds. 42 U.S.C. §294.

(26) Grants for the construction of facilities for research in the field of mental retardation. 42 U.S.C. §295a.

(27) Grants for traineeships in family medicine, and for the support of postgraduate training programs for physicians, dentists, and health professions teaching personnel. 42 U.S.C. §§295d–1, 295e–1, 2, 3.

(28) Capitation grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy and podiatry. 42 U.S.C. §294f.

(29) Start-up grants to new schools of medicine, osteopathy, or dentistry. 42 U.S.C. §295f–1.

(30) Special project grants and contracts to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry. 42 U.S.C. §295f–2.

(31) Grants to assist schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry. 42 U.S.C. §295f–3.

(32) Grants to improve the distribution of health manpower. 42 U.S.C. §295f–4.

(33) Grants and contracts to provide training programs in emergency medical services. 42 U.S.C. §295f–6.

(34) Grants for construction and improvement of teaching facilities and training centers for allied health professions personnel. 42 U.S.C. §§295h, 295h–1, 2.

(35) Grants for scholarships and work-study programs, and loans for students of allied health professions. 42 U.S.C. §§295h–3b, 3c, 3d.

(36) Grants and loans guarantees for construction of new facilities and expansion of existing facilities for schools of nursing. 42 U.S.C. §§296a, 296d.

(37) Grants for establishment of nurse training programs, special project grants, and financial distress grants to schools of nursing. 42 U.S.C. §§296a, 296d, 296j, 296l, 296m.

(38) Capitation grants to schools of nursing. 42 U.S.C. §296e.

(39) Grants for scholarships, traineeships, and student loans for nursing students. 42 U.S.C. §§297, 297a, 297f, 297j.

(40) Grants and contracts to schools of nursing to encourage full utilization of educational talent. 42 U.S.C. §298c–7.

(41) Grants for planning, establishing, and operating regional medical programs and health services delivery programs. 42 U.S.C. §§299c, 299d, 299j.

(42) Grants and contracts for projects, training, and research relating to family planning programs. 42 U.S.C. §300, 300a–1, 2.

(43) Grants and contracts for projects for research and development of programs for diagnosis, control, and treatment of sickle cell anemia. 42 U.S.C. §300b–1.

(44) Grants for the development, establishment and expansion of comprehensive hemophilia diagnostic and treatment centers and blood separation centers. 42 U.S.C. §§300c–21, 22.

(45) Grants and contracts for establishment, operation, expansion, and improvement of emergency medical services systems. 42 U.S.C. §§300d–2, 3.

(46) Grants, contracts, loans, and loan guarantees for planning, development, and initial operation of Health Maintenance Organizations. 42 U.S.C. §§300e–3, 4.

(47) Grants, loans, and loan guarantees for construction, modernization, and conversion of medical facilities. 42 U.S.C. §§300p, 300q, 300s.

No. 77-971

In the Supreme Court of the United States

OCTOBER TERM, 1977

STATE OF NORTH CAROLINA EX REL.
SARAH T. MORROW, ET AL., APPELLANTS

v.

JOSEPH A. CALIFANO, SECRETARY OF HEALTH,
EDUCATION, AND WELFARE, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

MOTION OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE TO AFFIRM

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The Solicitor General, on behalf of the Secretary of Health, Education, and Welfare, moves that the judgment of the district court be affirmed.

OPINION BELOW

The opinion of the district court (J.S. App. a-1 to a-10) is unreported.

JURISDICTION

The judgment of the district court was entered on September 30, 1977. A notice of appeal to this Court

was filed on November 9, 1977 (J.S. App. b–1 to b–5), and the jurisdictional statement was filed January 6, 1978. The jurisdiction of this Court is invoked under 28 U.S.C. 1253.

QUESTION PRESENTED

Whether the National Health Planning and Resource Development Act of 1974, which provides for the payment of certain federal health care grants to the states on the condition that the states participate in an integrated health system plan, is a proper exercise of Congress' spending power.

STATEMENT

1. In 1974, Congress enacted the National Health Planning and Resources Development Act of 1974 (the Health Planning Act), 88 Stat. 2226, 42 U.S.C. (Supp. V) 300k to 300t, which provides for the creation of a national system of health care planning and development. Congress contemplated that the states would establish health planning agencies devoted to improving the accessibility and quality of health services, while restraining increases in health costs and preventing unnecessary duplication of health care resources. 42 U.S.C. (Supp. V) 300*l*–2. The Health Planning Act calls on each state health agency to administer a state "certificate of need" program. Under that program, the state agency would review all new institutional health services proposed for the state and would ensure that "only those services, facilities, and organizations found to be needed shall be offered or developed in the State." 42 U.S.C. (Supp. V) 300m–2(4)(B).

The Act gave the states until September 30, 1980, to elect or decline to participate in the national system described in the Act. States electing not to participate would not be eligible for federal grants under the Act and under related federal health programs. 42 U.S.C. 300m(d).[1]

2. On April 27, 1976, appellant North Carolina filed this action in the United States District Court for the Eastern District of North Carolina, challenging the constitutionality of portions of the Health Planning Act.[2] North Carolina contended that the comprehensive health planning system—and the certificate of need requirement in particular—violate the State's rights under the Tenth Amendment and the Guaranty Clause of Article IV, Section 4 of the Constitution. North Carolina further argued that the threatened loss of federal funds under the Act and under pre-existing Acts if the State should decline to participate in the Health Planning Act amount to "coercion" and therefore exceed the legitimate scope of Congress' spending power under Article I, Section 8, clause 1 of the Constitution.

North Carolina argued that its position was peculiarly difficult, because the Supreme Court of North Carolina had held that the state constitution pro-

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[1] The related programs are the Community Mental Health Centers Act, as added, 89 Stat. 309–333, 42 U.S.C. (Supp. V) 2689–2689aa, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, 84 Stat. 1848, and other portions of the Public Health Service Act, 58 Stat. 682, as amended, 42 U.S.C. (and Supp. V) 201 *et seq.*

[2] The other appellants, including the State of Nebraska, later intervened.

hibited the legislature from passing a "certificate of need" statute of the kind envisaged by the Health Planning Act. *In the Matter of Certificate of Need for Aston Park Hospital, Inc.,* 282 N.C. 542, 193 S.E. 2d 729. Unless the state supreme court reversed itself on the issue, the state argued, an amendment of the state constitution would be essential to enable North Carolina to participate in the Health Planning Act program.

The district court rejected appellants' arguments, holding that the Health Planning Act is a permissible exercise of Congress' spending power, and that it does not violate either the Tenth Amendment or the Guaranty Clause. The court observed that Congress' effort to establish and pay for a national health program is a legitimate national purpose. It stated (J.S. App. a–5):

> Without question Congress in making grants for health care to the States, should be vitally concerned with the efficient use of the funds it appropriated for that purpose. It had a perfect right to see that such funds did not cause unnecessary inflation in the cost of health costs to the individual patient. It certainly had the power to attach to its grants conditions designed to accomplish that end.

Although the federal "certificate of need" program applies to private as well as public health care facilities, the court held that inclusion of private facilities is justified because, "if only public construction were covered by the certificate of need program, the public interest in avoiding unnecessary increases

in health care [costs] by reason of the addition of unneeded additional facilities could be thwarted by private construction" (J.S. App. a–8).

The district court rejected on several grounds North Carolina's argument that the use of the spending power in the Health Planning Act is unconstitutional because it "coerces" the State into participating in the health planning program. First, relying on *Steward Machine Co.* v. *Davis,* 301 U.S. 548, the court noted (J.S. App. a–5 to a–6):

> [W]henever the condition attached by Congress to an appropriation grant available to the States relates to a "legitimately national" purpose, inducement or temptation to conform does not go beyond the bounds of the federal government's legitimate spending power and is not coercion in any constitutional sense.

Second, the court observed that the amount of federal money that North Carolina would be denied by electing not to participate in the program would be less than 50 million dollars per year. In light of the state's annual revenues of 3.1 billion dollars, the court concluded (J.S. App. a–7) that the threat of loss of that sum "could hardly be described as 'catastrophic' or 'coercive.'"

Finally, the court held that the North Carolina court's ruling that participation in the federal health program would violate the North Carolina Constitution does not render the Health Planning Act unconstitutionally coercive. "The validity of the power of the federal government under the Constitution to im-

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pose a condition on federal grants made under a proper Constitutional power," the court wrote, "does not exist at the mercy of the State Constitutions or decisions of State Courts" (J.S. App. a–7).

ARGUMENT

1. The Health Planning Act is one of many federal statutes that condition the disbursement of federal funds on compliance with federal standards. Many of these statutes make payment of federal funds conditional on the states' agreement to comply with a detailed regulatory plan that may require legislative action by the State.[3] Such statutes have long been held to be permissible exercises of the spending power, and

[3] See, *e.g.*, the Federal Aid Highways Act, as added, 88 Stat. 2286, 23 U.S.C. (Supp. V) 154 (conditioning payment of all federal highway aid to a State on the State's agreement to enact 55 miles per hour speed limits on all highways within its jurisdiction); Title XIX of the Social Security Act, as added, 79 Stat. 343, and amended, 42 U.S.C. (and Supp. V) 1396 *et seq.* (conditioning payment of Medicaid funds to a State on the enactment of a State plan, found satisfactory by the Secretary of HEW, imposing various administrative requirements on the State's political subdivisions); Title VI of the Civil Rights Act of 1964, 78 Stat. 252, as amended, 42 U.S.C. (and Supp. V) 2000d *et seq.* (in conjunction with 45 C.F.R. Part 80, conditioning all federal aid to education on the State's submission of a comprehensive desegregation plan found satisfactory by the Secretary of HEW); the Federal Water Pollution Control Act of 1972, as added, 86 Stat. 816, 33 U.S.C. (Supp. V) 1251 *et seq.* (conditioning federal appropriations to the states for pollution control and construction of waste treatment and water purification facilities on the states' adoption of plan and certificate procedures found satisfactory by the Administrator of the Environmental Protection Agency); Title IV–A of the Social Security Act, 49 Stat. 627, 628, as amended, 42 U.S.C. (and Supp. V) 602, 603 (conditioning federal appropriations for aid to families with dependent children on the states' enactment of a detailed

appellants have not cited a single instance in which any such "conditional" statute has been held unconstitutional.

Seeking to avoid the force of an unbroken line of precedent against their position,[4] appellants contend that the Health Planning Act exceeds the limits of the spending power because it constitutes coercion rather than inducement (J.S. 8); because health care traditionally has been regarded as an area of particular state and local concern (J.S. 8–9); because the "penalty" prescribed by the Act bears little or no rational relationship to the Act's regulatory objective (J.S. 9); and because there are less drastic methods of dealing with health cost control than those prescribed by the Health Planning Act (J.S. 9–10). None of these contentions is persuasive.

a. Appellants' theme that the Health Planing Act exposes the states to "coercion" substitutes assertion

administrative plan approved by the Secretary); the Coastal Zone Management Act of 1972, as added, 86 Stat. 1280, 16 U.S.C. (1976 ed.) 1451 *et seq.* (conditioning appropriation of federal funds to the States for coastal zone management on the adoption by the States of a comprehensive planning program approved by the Secretary of Commerce).

[4] See, *e.g.*, *King* v. *Smith*, 392 U.S. 309, 333 n. 34; *Ivanhoe Irrigation District* v. *McCracken*, 357 U.S. 275, 295; *Oklahoma* v. *Civil Service Commission*, 330 U.S. 127, 143; *Helvering* v. *Davis*, 301 U.S. 619; *Steward Machine Co.* v. *Davis*, 301 U.S. 548; *Massachusetts* v. *Mellon*, 262 U.S. 447, 480.

Similarly, the Health Planning Act has been upheld in each of the other cases in which it has been challenged as unconstitutional. See *Goodin* v. *Oklahoma*, 436 F. Supp. 583 (W.D. Okla.); *National Association of Regional Medical Counsels* v. *Califano*, D. D.C., Civ. No. 76–0369, decided June 8, 1976, appeal pending, C.A.D.C., No. 76–2002; *King County* v. *Califano*, W.D. Wash., C77–723V, decided March 6, 1978.

for analysis. To be sure, by declining to participate in the national health planning program, North Carolina would become ineligible for certain federal health care grants. But, as the district court pointed out, the amount of money at stake, even on the state's estimate, is small in comparison with the state's annual revenues.

For years, more than a dozen states declined to participate in the Medicaid program, which involves far more federal money than the Health Planning Act. Indeed, the State of Arizona still does not participate in the Medicaid program, presumably because of its choice not to accept the federal conditions. *Report of the Staff to the Senate Committee on Finance, Medicare and Medicaid, Problems, Issues and Alternatives* (1970). Although North Carolina would prefer to enjoy federal health funds without having to accept Congress' conditions, the Health Planning Act cannot fairly be said to have deprived the state of any choice in this matter. See *Steward Machine Co.* v. *Davis*, 301 U.S. 548, 589–591. The fact that the choice involves a selection between ends valued by appellants, and the sacrifice of one to obtain more of the other, may make the choice hard, but it is not "coercive" to put someone to a hard choice. See *Bordenkircher* v. *Hayes*, No. 76–1334, decided January 18, 1978; *McGautha* v. *California*, 402 U.S. 183, 208–220.

b. Appellant's contention that public health is a field traditionally left to local regulation is undercut by their repeated emphasis on the pervasive and essential role played by federal funding in the health

care field. The federal government, through Medicare, Medicaid, and other programs, is a substantial participant in health service provision, and appellants do not challenge these programs. If appellants suggest that health care should be paid for by Congress but regulated by the states,[5] we submit that nothing in the Constitution requires Congress to abandon its own attempts to ensure the efficient use of federal monies. The Health Planning Act was designed to maximize the effectiveness of federal funding, while curbing the rapid increase of health care costs that had been fueled in part by "[t]he massive infusion of Federal funds into the existing health care system." 42 U.S.C. (Supp. V) 300k(a)(2). See S. Rep. No. 93–1285, 93d Cong., 2d Sess 40 (1974); H.R. Rep. No. 93–1382, 93d Cong., 2d Sess. 31 (1974).[6]

c. Congress' conclusion that a comprehensive approach to health care is needed to achieve these goals answers appellants' contentions that withholding federal funding for a variety of health care programs

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[5] Appellants' assertion that states are "fully capable of regulating" the provision of health care (J.S. 8; footnote omitted) conflicts with their own assertion that North Carolina is forbidden by its constitution to regulate health care in certain ways (J.S. 4–5, 11).

[6] In the 1977 fiscal year alone, federal health care spending was estimated to be $51.4 billion, or 12.5 percent of all federal expenditures. The federal government assumes almost one-third of all health-related costs in the country. Its share of total health spending has more than doubled since 1965, while the state and local governments' share has remained about the same. Moreover, inflation in health care costs has significantly outrun the Consumer Price Index, with hospital costs leading the way. Office of Management and Budget, *Special Analysis Budget of the United States Government Fiscal Year 1978*, 202–228.

is unrelated to the purposes of the Health Planning Act, and that less drastic means could have been devised to achieve the same goals. Appellants appear to assume that the provision of the Health Planning Act denying federal funding for various pre-existing health programs in non-complying states was intended as a fitting "punishment" for "misconduct". Quite the contrary, the Health Planning Act simply followed the lead of a series of federal statutes designed to assure that federal funds would not continue to be used to "pay for costly services which the planning process determines are unneeded." S. Rep. No. 93–1285, *supra,* at 7; see 42 U.S.C. (Supp. V) 300k (a) (2).

Moreover, the three federal grant statutes referred to in the Health Planning Act were selected because they are required to be administered by agencies established under the Act. 42 U.S.C. (Supp. V.) 300*l*–2(e)(1)(A)(i), 300m–(c)(6). A state's election not to participate in the Health Planning program means that the state will lack the mechanism that Congress deemed necessary to the efficient expenditure of those federal funds. Accordingly, the "conditions" of the Health Planning Act are precisely tailored to its purpose to spend designated monies efficiently to achieve specified purposes; the means used for the exercise of the spending power are "appropriate and plainly adapted to the permitted end." *Oklahoma* v. *Civil Service Commission,* 330 U.S. 127, 143; *United States* v. *Darby,* 312 U.S. 100, 124.

d. Appellants highlight their "coercion" argument with the assertion that the Act's certificate of need

requirement is "repugnant to [North Carolina's] constitution" (JS. 2). That assertion, however, may be subject to question. The Supreme Court of North Carolina held a previous certificate of need program contrary to the state constitution, but the current federal requirements for certificates of need programs (42 Fed Reg. 4022–4032 (1977)) leave the states so much flexibility in designing their programs that it is entirely possible a program could be devised in North Carolina that would satisfy both the Health Planning Act and the state constitution.

In any event, it should make no difference whether a state changes its constitution or simply its laws in order to qualify for grants offered by Congress in the exercise of its spending power. The central point is that a state may elect either the money (with its conditions) or the status quo. It is irrelevant, so far as the United States Constitution is concerned, whether the state rule to be altered is constitutional, statutory, decisional, or simply one of custom. *Townsend* v. *Swank,* 404 U.S. 282, 286; *Carleson* v. *Remillard,* 406 U.S. 598, 601.[7]

e. Appellants repeatedly refer to *National League of Cities* v. *Usery,* 426 U.S. 833, and *Environmental Protection Agency* v. *Brown,* 431 U.S. 99, which they contend establish limits on the power of Congress to set.

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[7] Other state constitutions have not been found to be inconsistent with the establishment of certificate of need programs. See, *e.g.*, *Goodin* v. *Oklahoma, supra; Merry Heart Nursing and Convalescent Home, Inc.* v. *Dougherty,* 330 A. 2d 370 (N.J. App.); *Simon* v. *Cameron,* 337 F. Supp. 1380 (C.D. Cal.); *Attoma* v. *State Department of Social Welfare,* 26 App. Div. 2d 12, 270 N.Y.S. 2d 167.

rules binding on the states. The statutes involved in those cases, however, were not "conditional" exercises of the spending power; they imposed mandatory requirements on the states. The analysis in *National League of Cities* and in the lower court opinions in *Brown* and its companion cases is therefore not applicable here. As this Court has recently observed, governmental power "to encourage actions deemed to be in the public interest is necessarily far broader" than the government's power "to impose its will by force of law." *Maher* v. *Roe,* 432 U.S. 464, 476. The Health Planning Act simply encourages state action that Congress believes worth paying for.[8] It does not command the states; it does not threaten their separate or independent existence. It therefore does not exceed the limitations on Congress' power identified in *National League of Cities.*

2. Appellants also argue (J.S. 10–12) that the Health Planning Act violates the Guaranty Clause of Article IV, Section 4 of the Constitution. The short answer to this contention is that this Court has long held that questions arising under the Guaranty Clause are political in character and therefore not justiciable. *Baker* v. *Carr,* 369 U.S. 186, 218–232; *Highland Farm Dairy* v. *Agnew,* 300 U.S. 608; *Ohio* v. *Akron Park District,* 281 U.S. 74; *Pacific States Telephone & Telegraph Co.* v. *Oregon,* 223 U.S. 118; *Luther* v. *Borden,* 7 How. 1.

[8] In *Buckley* v. *Valeo,* 424 U.S. 1, 57 n. 65, 97–104, this Court drew a parallel distinction, holding that although the government could not forbid a candidate from spending funds, it could use its spending power to induce him not to spend those funds.

There would be no ground for concern here even if the issue were justiciable. Congress has designed the cooperative regulatory scheme under the Health Planning Act in a manner that minimizes interference with state autonomy. The Act induces states to act in particular ways, but the regulatory program it envisages no more denies any states a republican form of government than does the regulation states already provide (J.S. 8–9) or the displacement of state choices compelled by the Supremacy Clause. See, *e.g., Ray* v. *Atlantic Richfield Co.,* No. 76–930, decided March 6, 1978 (federal tanker regulation preempts state laws, even though that annuls important state policies).

Moreover, although the Act sets out broad criteria for an integrated system of health care planning and review, the Secretary is not involved in the substantive decision-making or staffing of the locally controlled health systems agencies, and the state governors are given nearly absolute discretion to designate the state agency of their choice to administer the state administrative programs. 42 U.S.C. (Supp. V) 300m (b)(1). The Secretary has no control over the implementation of the state plans and may not interfere with the state agencies' substantive determinations whether to issue particular certificates of need. The Act allows the states' governors broad discretion to designate existing state agencies to take charge of the certificate of need program. 42 U.S.C. (Supp. V) 300m(b)2. In light of these provisions, appellants' concern that the Act denies the states a republican form of government is unwarranted.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

APPELLANTS' BRIEF IN OPPOSITION TO MOTION TO AFFIRM

The Motion of the Secretary of Health, Education and Welfare (hereinafter "Motion") to affirm the decision of the District Court below upholding the constitutionality of the National Health Planning and Resources Development Act of 1974 (42 U.S.C. §300k *et seq.*) demonstrates that plenary review of that decision is essential.* The Secretary apparent-

*The opinion and order of the United States District Court for the Eastern District of North Carolina, as well as the background and procedural posture of this litigation have been set forth in Appellants' Jurisdictional Statement filed on January 6, 1978.

ly does not dispute the fact that this case raises the important question explicitly left open in *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n.17 (1976): Whether there are any meaningful limits on use of the spending power to interfere with integral operations of state governments. Instead, the Secretary urges the Court to answer that question summarily by affirming a holding that there are no such limits. Appellants respectfully submit that a matter of such significance requires plenary review by this Court.

I. The Health Planning Act Exceeds The Spending Power Of Congress

Contrary to the assertions of Appellee, the Health Planning Act is not simply another "one of many federal statutes that condition the disbursement of federal funds on compliance with federal standards" (Motion, p. 6). The Health Planning Act does *not* merely set forth the conditions a state must meet to qualify for federal funds made available under the Act. Rather, it requires each state to enact Congressionally-mandated legislation or forfeit all federal funds under approximately fifty other health care programs that had been jointly funded by state and federal governments for many years prior to passage of the Health Planning Act.

These programs, listed in Appendix D to Appellants' Jurisdictional Statement, were established over the years by many different Congresses concerned with advancing medical science and meeting the health care needs of the American people. They have been relied upon by the states in constructing state health care systems and have become essential to the functioning of those systems. Yet all benefits under these laws would be lost by the failure of a state to comply with the dictates of the Health Planning Act.

There is no real dispute about the fact that the continuation of these long-standing programs is critical to the health care of the citizens of Appellants State of North Carolina and State of Nebraska. Consequently, these States simply cannot permit such funding to be terminated.* New doctors, dentists, nurses and auxiliary medical personnel will go untrained. Medical research will go unfinished. And thousands of sick people—those suffering from diabetes, chronic alcoholism, mental illness, circulatory problems, venereal disease, sickle cell anemia, and many other afflictions—will go untreated. Thus, no prior exercise of the spending power even begins to approach the Health Planning Act in its coercive effect on the states.

Although Appellee contends that an "unbroken line of precedent" supports the decision below (Motion, p. 7), analysis of Appellee's extensive citations and discussion reveals not one decision of this Court which supports the unprecedented exercise of the spending power found in the Health Planning Act. The statute at issue in *Oklahoma* v. *Civil Service Commission*, 330 U.S. 127 (1947) (Motion, p. 7, n.4), §12 of the Hatch Act, provided that if a state or local official whose principal employment was in connection with any federally financed activity took an active part in any political campaign, the state or local agency would lose an amount equal to two years' compensation at the rate such

*On at least two occasions (Motion, pp. 5, 7–8), Appellee suggests that the termination of funds threatened by the Health Planning Act is not coercive because such funds are only a relatively small percentage of the total budget of the Appellant States. The conspicuous flaw in Appellee's argument is that it assumes that the states have substantial excess funds to allocate to the programs whose federal funding is terminated and that state activities other than those related to public health can bear some of the burden of the loss of funds. Both of those assumptions are utterly inconsistent with the fiscal realities of state governments today.

official was receiving at the time of the violation. Of this sanction, like the sanction involved in *Massachusetts* v. *Mellon*, 262 U.S. 447 (1923) (Motion, p. 7, n.4), it can truly be said that the state could as a practical matter adopt "the 'simple expedient' of not yielding". *Oklahoma* v. *Civil Service Commission*, *supra*, 330 U.S. at 143. Here, in contrast, the "simple expedient of not yielding" is simply not available. In addition, unlike the Health Planning Act, the Hatch Act did not require the enactment of legislation by a state, the fundamental attribute of state sovereignty, see *Maryland* v. *EPA*, 530 F.2d 215, 225 (4th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 431 U.S. 99 (1977). Indeed, the primary impact of the Hatch Act was on the political activities of individual citizens, and restriction of such individual activity was upheld even when imposed directly on federal employees. *United Public Workers of America* v. *Mitchell*, 330 U.S. 75 (1947).

The other cases cited by Appellee are even less in point. Appellants do not dispute that the ". . . Federal Government, unless barred by some controlling constitutional prohibition, may impose the terms and conditions upon which its money allotments to the states shall be disbursed . . . ." *King* v. *Smith*, 392 U.S. 309, 333 n.34 (1968). But the Health Planning Act does far more. It mandates forfeiture of all benefits under approximately fifty pre-existing federal programs unrelated to the Health Planning Act if a state fails to enact legislation which may be offensive to its public policy or violative of its constitution. Thus, it involves not "a scheme of cooperative federalism" endorsed by this Court in *King* v. *Smith*, *supra*, 392 U.S. at 316, but a "coercive federalism" in which the federal government exercises its overwhelming spending power to force states to yield to the Congressional decree.

More recent decisions of the Court indicate that the Health Planning Act exceeds the spending power of Congress.

In *Fry* v. *United States*, 421 U.S. 542 (1975), the Court recognized that the Tenth Amendment "expressly declares the constitutional policy that Congress may not exercise power in a fashion that impairs the States' integrity or their ability to function effectively in a federal system." 421 U.S. at 547, n.7. This Court has made it clear, and Appellee has therefore conceded (Motion, pp. 11–12), that Congress could not have relied upon the Commerce Clause to force a state to enact legislation. *National League of Cities* v. *Usery*, *supra*. See also *Oregon* v. *Mitchell*, 400 U.S. 112, 128 (1970). In so doing, the Court was careful explicitly to reserve for resolution in the context of a concrete case or controversy the complex and fundamental question of whether the Constitution imposes any limits on the extent to which Congress may use its spending power to accomplish indirectly a result which it cannot attain directly under the Commerce Clause. 426 U.S. 833, 852 n.17 (1976). But the holding of *National League of Cities* would be rendered meaningless if Congress were permitted to circumvent the limitations on its power under the Commerce Clause by relying on its power to tax or to spend. See Comment, *Toward New Safeguards on Conditional Spending: Implications of National League of Cities* v. *Usery*, 26 Am. U. L. Rev. 726 (1977). For, as the Court noted in *United States* v. *Butler*, 297 U.S. 1 (1936):

> "If, in lieu of compulsory regulation . . . which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end, clause 1 of §8 of Article I would become the instrument for total subversion of the governmental powers reserved to the individual states." 297 U.S. at 75.

Moreover, the reasoning in *National League of Cities* suggests that it is the effect of Congressional action on state sovereignty, and not the particular clause upon which such action is predicated, which determines the constitutionality

of a statute such as the Health Planning Act. The ultimate question for resolution was whether Congress had abrogated state powers with respect to "'functions essential to separate and independent existence'". 426 U.S. at 845-846, citing *Coyle* v. *Smith*, 221 U.S. 559, 580 (1911). The Court went on to suggest that the Constitution places limits on this process even when it is purportedly justified under grants of power other than the Commerce Clause:

> "This Court has never doubted that there are limits upon the power of Congress to override state sovereignty, even when exercising its otherwise plenary powers *to tax* or to regulate commerce." 426 U.S. at 842. [Emphasis added]

II. The Guaranty Clause Prohibits Exercise of the Spending Power in a Manner Which Strips States of Essential Functions of Self-Government.

Appellee asserts (Motion, p. 12) that questions arising under the Guaranty Clause are not justiciable. The apparent basis for this position is that *some* cases have held that *some* such questions are not justiciable. The logical fallacy of Appellee's position has been recognized:

> "The nature of the question, therefore, and not the mere invocation of the clause, determines whether a contention is justiciable and the clause judicially enforceable." *Kohler* v. *Tugwell*, 292 F. Supp. 978, 984-985 (E.D. La. 1968) (Wisdom, J.), *aff'd*., 393 U.S. 531 (1969).

See also *Burger* v. *Judge*, 364 F. Supp. 504 (D. Mont.), *aff'd*., 414 U.S. 1058 (1973). This Court also has indicated that questions raised under the Guaranty Clause are justiciable when not "political" in nature and where there is not a clear absence of judicially manageable standards. See *Reynolds* v. *Sims*, 377 U.S. 533, 582 (1964).

Appellants' position on the Guaranty Clause (Jurisdictional Statement, pp. 10-12) is certainly not refuted by Appellee's contention that the Health Planning Act "no more denies any states a republican form of government than does the regulation states already provide or the displacement of state choices compelled by the Supremacy Clause." (Motion, p. 13) [citations omitted]. The same analogy to displacement of state choices under the Supremacy Clause was rejected in *Brown* v. *EPA*, 521 F.2d 827 (9th Cir. 1975), *cert. granted*, 426 U.S. 904 (1976), *vacated as moot*, 431 U.S. 99 (1977):

> " 'Federal law often says to the states, 'Don't do any of these things,' leaving outside the scope of its prohibition a wide range of alternative courses of action. But it is illuminating to observe how rarely it says, 'Do *this* thing,' leaving no choice but to go ahead and do it. The *Federalist* papers bear ample witness to the Framers' awareness of the delicacy, and the difficulties of enforcement, of affirmative mandates from a federal government to the governments of the member states.' " 521 F.2d at 841, citing H. Hart, *The Relations Between State and Federal Law*, 54 Colum. L. Rev. 489, 515 (1954).

CONCLUSION

In recent years, Congress has demonstrated an increasing propensity to use its spending power to control the activities of state governments. The Health Planning Act, however, represents a radical new use of that power, for in the Act, Congress has tied the continuation of scores of long-standing health care programs to acceptance of unprecedented, coercive interference with state governmental functions.

In *Steward Machine Company* v. *Davis*, 301 U.S. 548 (1937), the Court recognized that defining the scope of the powers of Congress to tax and to spend is a difficult task:

> "We do not fix the outermost line. Enough for present purposes that wherever the line may be, this statute is within it. Definition more precise must abide the wisdom of the future." 301 U.S. at 590–591.

Appellants respectfully submit that the time has now come for a "definition more precise" of the spending power.

Respectfully submitted,

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IN THE

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OCTOBER TERM, 1977

No. 77-971

STATE OF NORTH CAROLINA EX. REL. SARAH T. MORROW; STATE OF NEBRASKA; AMERICAN MEDICAL SOCIETY; AND NORTH CAROLINA MEDICAL SOCIETY, *Appellants,*

v.

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On Appeal From The United States District Court For The Eastern District of North Carolina

MOTION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* PACIFIC LEGAL FOUNDATION IN SUPPORT OF JURISDICTIONAL STATEMENT

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On Appeal From The United States District Court For The Eastern District of North Carolina

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MOTION OF PACIFIC LEGAL FOUNDATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF JURISDICTIONAL STATEMENT

Pacific Legal Foundation (PLF) hereby moves, pursuant to Supreme Court Rule 42, for leave to file the annexed brief *amicus curiae* in support of the Jurisdictional Statement submitted by Appellants on January 6, 1978, in the above captioned proceeding.

Pacific Legal Foundation is a non-profit, tax-exempt corporation organized and existing under the laws of California for the purpose of engaging in litigation in matters affecting the broad public interest. The Foundation has more than 20,000 contributors and supporters throughout the United States. Policy for the Foundation is set by a Board of Trustees composed of concerned citizens, the majority of whom are attorneys.

The Foundation has participated in, and has devoted a significant portion of its resources, to cases involving federal usurpation of state and local governmental functions. PLF has been a party plaintiff in *EPA* v. *Brown*, 521 F.2d 827 (9th Cir., 1975), *cert. granted* 426 U.S. 904 (1976), *vacated as moot* 97 S. Ct. 1635 (1977), and is now a plaintiff challenging the federal flood insurance program. *Texas Landowners' Rights Association* v. *Harris*, No. 77-1962 (D.D.C., filed Nov. 15, 1977). The Foundation is concerned with the growing number of federal programs which, although denominated as voluntary, are implemented through the threat of loss of federal revenues.

The accompanying brief urges this Court to note probable jurisdiction. Pacific Legal Foundation can bring to this case a diverse perspective not presently represented which will assist in obtaining full consideration of public interest issues.

Accordingly, Pacific Legal Foundation respectfully requests leave to file the annexed brief *amicus curiae*.

Respectfully submitted,

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On Appeal From The United States District Court For The Eastern District of North Carolina

BRIEF OF *AMICUS CURIAE* PACIFIC LEGAL FOUNDATION IN SUPPORT OF THE JURISDICTIONAL STATEMENT

INTEREST OF AMICUS

Pacific Legal Foundation (PLF) is a non-profit, tax-exempt corporation organized and existing under the laws of California for the purpose of engaging in litigation in matters affecting the broad public interest.

PLF is currently a plaintiff in *Texas Landowners' Rights Association* v. *Harris*, No. 77-1962 (D.D.C. filed Nov. 15, 1977), which involves the federal flood insurance program and which presents a similar issue to that in this case. The background and interests of *amicus* are detailed in the preceding motion for leave to file this brief.

INTRODUCTION

This case presents issues directly affecting the allocation of power between the federal government and state governments. The affirmative limitation on federal intrusions under the commerce power into state and local sovereignty established in *National League of Cities* v. *Usery*, 426 U.S. 833 (1976), should now be explicitly extended to include the spending powers of Congress, U.S. Const. art. I, § 8, cl. 1.

Laws enacted to coerce implementation of spending programs by state and local governments should be invalidated because they significantly impair the ability of state and local governments to function independently in the federal system. The issue presented for review is:

> Whether Acts of Congress which withhold previously committed funds for the purpose of coercing states into enacting legislation and surrendering control over traditional areas of local authority are consistent with the Constitutional guarantee of a republican form of government and the inherent powers of the states.

ARGUMENT

I. This Court's Decision Would Establish Valuable Precedent For Evaluation Of Current Legislation And For Resolution Of Issues In Cases Pending Before Lower Courts.

The issue presented herein is far-reaching; the possibility for dispensing, withholding or withdrawing of federal funds pervades numerous acts of Congress.

In this case, it is health care that is held ransom. Having encouraged the states to establish a variety of health-care programs for the treatment of a number of serious disorders, Congress is now withholding funds from those prior programs, unless and until the state enacts required legislation to implement a new or different program.

This commandeering of existing programs to force acceptance of new programs, which the community would reject on the merits, is not an isolated act. For example, in the federal flood insurance program, the Veteran's Administration is withholding V.A. loans from qualified veterans and the Federal Housing Authority is withholding home improvement loans from qualified individuals simply because the individuals live in communities which have refused to accept the direct incentives and burdens of the program. Growth in these communities is greatly restricted because of the program. Thus both individuals and the community are being coerced to accept the flood insurance program, unacceptable on its own merits, to avoid being cut out of other federal programs which were established for many years for the purposes of aiding needy veterans and encouraging home ownership, home improvement and employment.

Veterans, home owners, construction workers and communities are as seriously impacted by the coercive restrictions of flood insurance as the hemophiliacs, mentally ill, diabetics, and others with serious medical problems are threatened by termination of needed public health services. Because of this far reaching effect, and because of the potential for repetitive litigation where Congress' conditional spending power is used coercively, this Court should take jurisdiction.

II. The Public Interest Requires This Court To Define The Limitations On Congressional Spending Powers.

In *National League of Cities* v. *Usery*, 426 U.S. 833, 852 n. 17 (1976), the Court stated:

> We express no view as to whether different results might obtain if Congress seeks to affect integral operations of state governments by exercising authority granted it under other sections of the Constitution such as the spending power, Art. I § 2, Cl. 1, or § 5 of the Fourteenth Amendment.

The Court is now squarely presented with this issue, and its resolution will affect the fabric of the American democracy. If the limitations on congressional exercise of the commerce power established in *National League of Cities* is to have any meaning, the principle must extend to the federal spending power. Statutes such as the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300(k) *et seq.* (1976) [Health Planning Act], are not merely simple grants with conditions which may be rejected without significant ramifications in other programs. Rejection of a voluntary program leaves the rejecting party in the status quo. The Health Planning Act is a deliberate and calculated attempt to coerce compliance through

the termination of prior health programs. This use of the spending power moves beyond the traditional dichotomy of "voluntary" and "involuntary" programs and challenges the ability of state governments to function independently in a republican form of government.

Pacific Legal Foundation urges this Court to establish guidelines against which conditional spending statutes will be measured to insure that the constitutional limitations in the Tenth Amendment and the Guarantee Clause, art. IV, § 4, will not be transgressed.

III. Conflicts Between Federal And State Power Require Adoption Of A Balancing Approach.

Every action by a state in adopting a federal program involves the relinquishment of some part of that state's ability to govern itself independent of federally imposed requirements. When such action is taken out of fear of retribution there has been no free choice, and it is the lack of free choice which results in the federal intrusion into the sovereign affairs of the state. By no stretch of the imagination can the Health Planning Act be said to offer free choice. As is clear from the Appellants herein, but for the coercive conditions some states would reject the program being offered.

For example, the State of North Carolina is forbidden by its Constitution from implementing the federal program. *In Re Certificate of Need For Aston Park Hospital, Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973). Therefore, Appellant North Carolina is subject to the penalty of forfeiting all federal funding for approximately fifty public health programs. This will

have an enormous negative impact upon the ability of the state to provide essential services.

Accordingly, the Foundation urges that this Court apply a three part test [1] to determine whether state sovereignty has been unconstitutionally impaired by the Health Planning Act.

First, the activity regulated by Congress should be an attribute of state sovereignty. Second, the activity should be a function essential to the separate and independent existence of the state. Third, there must be a balancing of adverse affects of the statute on the state and local government against the national interest served.

The facts in this case are well suited to the application of this three part test. First, the regulations of public health and medical care is a traditional function of the state. As this Court stated in *National League of Cities:*

> While there are obvious differences between the schools and hospitals involved in *Wirtz,* and the fire and police departments affected here, *each provides an integral portion* of those governmental services which the states and their political subdivisions have traditionally afforded their citizens. 426 U.S. at 855. (Emphasis added.)

Second, health planning is a function essential to the separate and independent existence of state governments. Public health has traditionally been recognized

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[1] Comment, *Toward New Safeguards on Conditional Spending: Implications of National League of Cities* v. *Usery,* 26 Am. U. L. Rev. 726, 729-730 (1977). This comment contains an excellent discussion of how this process will serve as a framework for demonstrating the affirmative limitation of federalism.

as a state and local function because the individual state is best suited to assess the particular needs of residents and to recognize the elements of free choice of the individual in selecting health care.

Finally, a balancing of the adverse affect of the Health Planning Act on the state government against the national interest reveals a conflict between the national goal for a more economical delivery of health care and the actual adverse effects of this statute upon approximately fifty health care programs in the State of North Carolina alone. While the national need for economical systems is laudable, surely this goal can be reached by means which is less intrusive into state and local governmental affairs. The Health Planning Act has an enormous negative impact upon the ability of states to provide essential health services.

Without a careful balancing of state and local needs against federal governmental goals, the conditional spending power of Congress will swallow up the guarantees of the Tenth Amendment and the Guarantee Clause of the Constitution. Whether confronted by federal programs regulating hospital care, state employee wages, or flood insurance, this Court must closely scrutinize the federal program.

CONCLUSION

In that the National Health Planning and Resource Development Act of 1974 violates the Tenth Amendment and the Guarantee Clause of the United States Constitution, Pacific Legal Foundation respectfully requests this Court note probable jurisdiction and find this law to be unconstitutional.

Respectfully submitted,

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

MOTION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF JURISDICTIONAL STATEMENT

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

MOTION OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF JURISDICTIONAL STATEMENT

Pursuant to Rule 42 of the Rules of this Court, the Association of American Physicians and Surgeons, Inc., respectfully moves the Court for leave to file a brief *amicus curiae* in the above--entitled case. Counsel for the movant mailed letters to counsel representing each of the respective Appellants and Appellees on December 2, 1977, inquiring whether each would give consent to the filing of a brief *amicus curiae*. As of the date the within motion is filed all but one of the parties have responded. Consent has been granted by the Solicitor General of the United States and Counsel

for the Appellee, American Association for Compresive Health Planning, Inc. The State of Nebraska has, likewise, given its complete consent. The American Medical Association, the North Carolina Medical Society and the State of North Carolina consented to the filing of a brief *amicus curiae* by the Association of American Physicians and Surgeons, Inc. provided "leave of the Supreme Court was obtained."

In support of the motion of the Association of American Physicians and Surgeons, Inc., for leave to file a brief *amicus curiae,* the Association states that it is a voluntary association formed by private, practicing physicians and surgeons in 1943. It is the largest association with nationwide membership in the United States devoted exclusively to representing the physician in the practice of private medicine. The Association has members in every State and territory in the United States, and in the District of Columbia. In addition, a substantial number of its members are not members of the American Medical Association, an Appellant herein, or of those medical associations within that federation. Thus many physicians who are members of the Association of American Physicians and Surgeons, Inc., are not represented by or through any of the parties to the instant appeal, yet will be directly and adversely affected by the comprehensive scheme of regulation of the practice of medicine and delivery of health care contemplated by the National Health Planning and Resources Development Act of 1974, 42 *U.S.C.* Subsection 300 k *et seq.*

A substantial number of the members of the Association have invested in, operate and maintain private health care facilities, the regulation of which is

the purpose of the "Act" in question. Certainly, their individual interests are at stake in the pending litigation, since such broad powers are granted to the Appellee Secretary of the Department of Health, Education and Welfare to regulate such private facilities, and even direct their "conversion to new uses."

The accompanying brief *amicus curiae* espouses the fundamental philosophy of the Association and its individual members, and presents an argument in both law and history which is unique to the instant case. Of importance to the Association is the argument, based upon the doctrine of Separation of Powers that quite independently of the Bill of Rights and the Fourteenth Amendment, the ***fundamental structure of the government of the United States*** guarantees the protection of personal liberties, *vested rights*, and, ultimately, vitality of local government.

The Association, additionally, presents the argument that the Founding Fathers were keenly aware that to preserve the Republic a yardstick must be exercised, by Courts, *quite independently of popular will,* to gauge the action of government. That, as the Court legitimately and properly found judicial review implied in the doctrine of separation of powers, so it must also find a historic duty to safeguard private property, individual liberty and fundamental, ***vested rights*** against arbitrary interference by the Congress, regardless what the popular will may be.

To a significant extent, the accompanying brief *amicus curiae* offered by the Association of American Physicians and Surgeons, Inc., relies upon principles of federalism and republican government, and, upon the doctrine of separation of powers. It is unique,

therefore, to the case at bar and such argument, otherwise, would not be brought before this Honorable Court.

CONCLUSION

For the above stated reasons, the Association of American Physicians and Surgeons, Inc., respectfully urges this Honorable Court to grant this motion for leave to file the accompanying brief *amicus curiae* in the present case in support of the jurisdictional statement.

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STATE OF NORTH CAROLINA EX. REL. SARAH T. MORROW; STATE OF NEBRASKA; AMERICAN MEDICAL ASSOCIATION; AND NORTH CAROLINA MEDICAL SOCIETY *Appellants*

v.

JOSEPH A. CALIFANO, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING, INC.; AND NATIONAL ASSOCIATION OF NEIGHBORHOOD CENTERS, *Appellees.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NORTH CAROLINA

BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF THE JURISDICTIONAL STATEMENT

MAY IT PLEASE THE COURT:

This brief *amicus curiae* in support of the Jurisdictional Statement is filed by the Association of American Physicians and Surgeons, Inc., by Motion, as provided for in Rule 42 of the Rules of this Court.

INTEREST OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

The Association of American Physicians and Surgeons, Inc., is the largest association in the United States devoted exclusively to representing the physician in the practice of private medicine. The Association has members in every State and territory in the United States and in the District of Columbia. In addition, a substantial number of its members are not members of the American Medical Association, an Appellant herein, or of those medical associations within that federation. Thus, many physicians who are members of the Association of American Physicians and Surgeons, Inc., are not represented by or through any of the parties to the instant appeal, yet will be directly and adversely affected by the comprehensive scheme of regulation and control of the practice of medicine and delivery of health care contemplated by the National Health Planning and Resources Development Act of 1974, 42 *U.S.C.* Subsection 300 k *et seq.* (hereinafter referred to as the "Act"). Members of the Association thus have a significant and concrete interest in the outcome of this appeal.

While believing that the Appellants in the instant case are seriously and skillfully defending their interests, the Association of American Physicians and Surgeons, Inc., is concerned lest their natural preoccupation with the issues which interest them most immediately will cause them, and hence this Court, to overlook the deeper, broader, and more ominous issues involved. The members of the Association, thus, are not adequately represented by the Appellants herein.

The Association believes that the legislation under attack here is premised upon the conclusion of the Congress of the United States that, under the *taxing and spending power*, like under the Commerce Clause, that body may regulate any and all activity conducted by mankind — so long as that activity, *somehow*, is clothed with some "national interest." The Members of the Association, being philosophically opposed to such a premise, it is their individual and collective belief that Congress has, under the "Act," arrogated to itself the power to annihilate, absolutely, the autonomy, and hence the responsibility and integrity, of state and local governments and, in addition, has arrogated to itself the power to errode the concept of, and, in fact, confiscate private property.

Specifically, the Association believes that if the "Act" in question is upheld Congress will have successfully blurred beyond recognition the distinctive lines between federal and state government, and the fundamental limitations placed, constitutionally, upon the government of the United States as being one of "limited and enumerated powers."

Being representative of private, practicing physicians only, the Association believes the most damaging impact of the "Act" in question will be upon the private, practicing physician who, even though he neither seeks nor receives money from the government, will, under the "Act," be directed to practice in specific institutions, utilize and invest in only such equipment as the federal government may approve, and thus be unable to render care to patients based upon his own best knowledge, judgment and resources. Such interference adversely affects the essential liberty a private, practicing physician must enjoy to render optimum health care, and adversely affects the vital "balance of rights" between government and citizens

inherent in the Constitution of the United States.

SUMMARY OF ARGUMENT

It must be accepted doctrine in American Constitutional Law that legislation enacted under the guise of the "common good" may well impair fundamental relationships between the federal government and the governments of the respective states, and may impair or undermine the *vested rights* of individual citizens, and, if either or both of those circumstances occurs or occur, such legislation must fail.

If the impact of the legislation amounts to "coercion" by the federal government of state legislatures, and, thereby, state legislatures are forced to enact legislation, then, regardless of the "common good," that legislation must fail to pass Constitutional muster. "Coercion" of states to legislate violates the very essence of *federalism*, and, importantly, violates the nation's historic and Constitutionally respected committment to *republican government* and the vitality of state and local government. The question circumscribed, therefore, relates to the *inherent nature and structure of the government of the United States.*

Vested rights and guarantees of personal liberty, though specifically found in the first eight amendments to the Constitution of the United States and in the Fourteenth Amendment thereof, are also found in the *fundamental structure of the government of the United States.* Wrote the late Mr. Justice John Marshall Harlan:

> We are accustomed to speak of the Bill of Rights and the Fourteenth Amendment as the principal guarantees of personal liberty. Yet it would be shallow not to recognize that the structure of our political system accounts not less for the free society we have. Indeed, it was upon the structure of government that the Founders primarily focused in writing the Constitution.

Harlan, "Thoughts at a Dedication: Keeping the Judicial Function in Balance," 49 *A.B.A.J.* 943-44 (1963).

To a great extent this brief *Amicus curiae* rests upon the foregoing thought. For, the Association believes that to uphold the "Act" would bury any hope that the fundamental rights and liberties of private citizens of this nation would check and, in turn, counter-balance what has, since 1932, become an uninhibited, albeit, explosive growth of federal authority, control and power.

The Association submits that the "Act" is violative of fundamental principles of *federalism* and *republican government,* for, the said "Act," by threatening the withdrawal of nonrenewal of pre-existing federal grant programs for the citizens of the respective states, coerces and forces the states to legislate requisite "certificate of need" programs. The Association firmly believes, therefore, that the "Act" contravenes both the Tenth Amendment and the "guaranty clause" of Article IV, Section 4, of the Constitution of the United States.

Furthermore, the Association submits that the "Act" unlawfully interferes with the privacy and confidentiality of the physician/patient relationship; and that it, on its face, grants the authority to the Defendant Secretary or those agents and agencies created and established thereunder to "take" private property without due process of law, and, therefore, is violative

of the First, Fifth, Ninth, Tenth and Fourteenth Amendment to the Constitution of the United States, and the doctrine of *vested rights.*

The Association is committed to the ascendance of a very fundamental principle of American Constitutional law which must, necessarily, predominate all specific amendments to the Constitution of the United States wherein rights and liberties are guaranteed, and that is, that the body of the Constitution itself, excluding all amendments, is the guarantor of personal liberty, freedom and individual rights. Wrote Mr. Justice Harlan:

> The Founding Fathers staked their faith that liberty would prosper in the new nation not primarily upon declarations of individual rights, but upon the kind of government the union was to have. It is manifest that no view of the Bill of Rights or interpretation of any of its provisions which fails to take due account of (federalism and separation of powers) . . . can be considered constitutionally sound.

Harlan, "The Bill of Rights and The Constitution," 50 *A.B.A.J.* 918, 920 (1964).

ARGUMENT

I.

THE FEDERAL GOVERNMENT AND THE STATES

A. By Requiring the States to Enact Legislation Upon Penalty of Forfeiture of Federal Funding Under Pre-existing Programs, the National Health Planning and Resources Development Act of 1974 Violates the Tenth Amendment to the Constitution of the United States, in Both Letter and Spirit, and Contravenes Fundamental Principles of Federalism.

Through a series of "interrelated" provisions, beginning with 42 *U.S.C.* Subsection 300 m (a), the National Health Planning and Resources Development Act of 1974 "instructs" the states to enter into and renew agreements with the Secretary of the Department of Health, Education and Welfare for the designation of a State Health Planning and Development Agency for each particular state No agreement may be consummated, however, unless the Governor of the State submits a "State Administrative Program" approved by the Appellee herein, and the State Health Planning and Development Agency has the authority and resources to administer the program. 42 *U.S.C.* Subsection 300 m-1.

The "State Administrative Program" must give the Appellee Secretary adequate assurance that the State agency has the authority *under State law* to carry out the health planning and development function set forth in 42 *U.S.C.* Subsection 300 m-2. See: 42 *U.S.C.* Subsection 300 m-2 (b) (1) (B).

Subsection 300 m-2 (a) (4) (B) of Title 42, *United States Code,* requires the State Agency to "administer a State 'certificate of need' program which applies to new institutional health services proposed to be offered or developed within the State . . " The "certificate of need" program must, under 42 *U.S.C.* Subsection 300 m-2 (a) (4) (B),

> provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed

in the State.

If a state fails to comply with the foregoing, the Appellee Secretary "may not make any allotment, grant, loan or loan guarantee, or enter into any contract under this Act (42 *U.S.C.* Subsection 201 *et seq.*), the Community Mental Health Centers Act (42 *U.S.C.* Subsection 2689 *et seq.*), or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 *U.S.C.* Subsection 4551 *et seq.*) for the development, expansion, or support of health resources in such state until such time as an agreement is in effect." 42 *U.S.C.* Subsection 300 m-3 (d).'

The "Act" is a blunt and brutal challenge to, not only the "sovereignty", but, the "legitimacy" of the States in our federal system. For the State of North Carolina, nothing short of an Amendment of its Constitution would permit it to qualify under the "Act," since the legislation regarding "certificate of need" such as that required by 42 *U.S.C.* Subsection 300 m-2 (a) (4) (B) has been held violative of the North Caro-

[1] No fewer than forty-seven federal grants, all established under pre-existing programs, are being used, here, as the coercive device. Grants for the care, treatment and rehabilitation of the mentally ill [42 *U.S.C.* Subsection 242 (a)], for graduate public health training. [42 *U.S.C.* Subsection 245 (a)], for communicable and other disease control programs [42 *U.S.C.* Subsection 247 (b)], for the planning and development of community health centers [42 *U.S.C.* Subsection 254 (c)], for the support of National Cancer Research and Demonstration Programs and Cancer Control Programs [42 *U.S.C.* Subsections 286 (b) and 286 (c)] and grants to provide training programs in emergency medical services [42 *U.S.C.* Subsection 295 (f) (6)] are among a few of those programs which the Congress and now the Defendant Secretary is using under the "Act" in question, as the coercive lever. The importance of continuing such allotments, grants, loans or loan guarantees and contracts is evident. The fact that they were created and established prior to, and hence, separate and apart from the "Act" in question is also evident.

lina Constitution. *In re Certificate of Need of Aston Park Hospital,* 282 *N.C.* 452, 193 *S.E.* 2d 729 (1973).

It is the contention of the Association that such a requirement contravenes the Tenth Amendment to the Constitution of the United States, and further, is violative of every legal and historical concept of "federalism."

"Federalism" is critical to the nation's existence under the Constitution. Before one may discuss a "popular will" as expressed by the Congress, an appeal must be made to the "popular will" expressed in the Constitution of the United States. Regardless what the Appellees deem is the "social need" upon which the Congress premised the "Act," the federal system cannot, under any legislative finding, be undermined. Wrote Mr. Justice Felix Frankfurter:

> The interpretations of modern society have not wiped out State lines. It is not for us to make indifference to its maintenance or excessive regard for the unifying sources of modern technology. Scholastic reasoning may prove that no activity is isolated within the boundaries of a single State, but that cannot justify absorption of legislative power by the United States over every activity.

Polish National Alliance v. N.L.R.B., 322 *U.S.* 643, 650, (1944).

Though formerly expressed as a "truism" — that "all is retained by the States which has not been surrendered . . .," the Tenth Amendment remains a declaration of the vital and essential relationship between the federal and state governments as that relationship was established by the Constitution before the Tenth Amendment was adopted and ratified.

United States v. Darby Lumber Co., 312 *U.S.* 100, 123-24 (1940).

The Tenth Amendment remains a "compelling reminder of America's search for union without unity." Mason, "The Supreme Court And Federalism," 44 *Tex. L. Rev.* 1187 (July, 1966). "Federalism" cannot coexist with "unity" or "uniformity."

The question raised by the National Health Planning and Resources Development Act of 1974 is whether it is compatible with "union" or whether it compels "unity." To the Association the answer is clear. The "Act" coerces state legislatures to pass specific legislation. It forces, in the case of the State of North Carolina, constitutional amendment. Nothing could be more incompatible with this nation's historic respect for the federal system.[2]

At the very dawn of the Republic's emergence there was ample proof that the formation of the "union" would not invite "unity." James Madison vigorously espoused such a concept. He wrote:

> But, if the Government be national with regard to the *operation* of its powers, it changes its aspect again when we contemplate it in relation to the extent of its powers. The idea of a *national* government involves in it, not only an authority over the individual citizens; but an indefinite supremacy over all persons and things so far as they are ob-

[2]To force the States to enact legislation or to amend their respective Constitutions denies them their essential meaning and purpose. For, by definition, "a State is a body politic, or society of men, united together for the purpose of promoting their mutual safety and advantage by the joint efforts of their combined strength." Cooley, T. M., *A Treatise On The Constitutional Limitations*, 1 (Boston, 1878); See also: *Chisolm v. Georgia*, 2 *U.S.* (2 Dall.) 419, 440, 457 (1782); *Georgia v. Stanton*, 73 *U.S.* (6 Wall.) 50 (1867).

> jects of lawful Government. Among a people consolidated into one nation, this supremacy is completely vested in the national legislature. Among communities united for particular purposes, it is vested partly in the general, and partly in the municipal legislatures. In the former case, all local authorities are subordinate to the supreme; and may be controlled, directed or abolished by it at pleasure. In the latter the local or municipal authorities form distinct and independent portions of the supremacy, no more subject within their respective spheres to the general authority, than the general authority is to them, within its own sphere. *In this relation then the proposed Government cannot be deemed a national one; since its jurisdiction extends to certain enumerated objects only, and leaves to the several States a residuary and invioable sovereignty over all other objects.* (Emphasis added.)

The Federalist, No. 39, 256 (Cook ed., 1967)

When the effect of Congressional legislation has been shown to "coerce" or force states to pass laws, this Honorable Court has invoked Mr. Madison's concept of "federalism." *National League of Cities v. Usery*, 426 U.S. 833 (1976). Quoting Mr. Justice Chase, the Court, in *National League of Cities*, reaffirmed that "[t]he Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States." *Texas v. White*, 74 *U.S.* (7 Wall.) 700 (1869).

The Court continued by reciting critical language in *Lane County v. Oregon*, 74 *U.S.* (7 Wall.) 71 (1869) at 76. Again, quoting Mr. Chief Justice Chase, the Court stated:

> Both the States and the United States existed before the Constitution. The people, through that instrument, established a more perfect union by substituting a national government, acting with

> ample power, directly upon the Citizens, instead of the Confederate government, which acted with powers, greatly restricted, only upon the States. But in many articles of the Constitution the necessary existence of the States, and, within their proper spheres, the independent authority of the States, is distinctly recognized.

National League of Cities v. Usery, supra, at 844.

In the words of James Madison, when discussing the "extent" of power, our government is "federal" not "national." *The Federalist*, No. 39, 256 (Cook ed., 1967). To Professor Mason the Tenth Amendment remains a "compelling reminder of America's search for union without unity." Mason, "The Supreme Court and Federalism," 44 *Tex. L. Rev.* 1187 (July, 1966).

As this Honorable Court held in the landmark decision involving legislation enacted under the commerce power, ". . . there are attributes of sovereignty attaching to every state government which may not be impaired by Congress, not because Congress may lack an affirmative grant of legislative authority, but because the Constitution prohibits it from exercising the authority in that manner." *National League of Cities v. Usery*, supra, at 253.

The Association submits that Congressional authority does have limits. Those limits are most pronounced when on considers the *effect* of a given enactment upon the *function* of state government. Whether the Congress of the United States enacts legislation under the "Commerce Clause" of Article I, Section 8, Clause 3, or the "taxing and spending power" of Article I, Section 8, Clause 1, it cannot, under either grant of power,

accomplish the compulsory regulation of the legislatures of State and municipal governments.

To examine the National Health Planning and Resources Development Act of 1974, 42 *U.S.C.* Subsection 300 k *et seq.* is to examine legislation the effect of which is to undermine and curtail the exercise of state legislative initiative. The Act, by its very title, and, by its effect, warps all traditional concepts of "federalism." It "coerces" states to enact "certificate of need" laws and to enter into and renew agreements with the Appellee Secretary of the Department of Health, Education and Welfare for the designation of State Health Planning and Development Agencies. Once such agencies are designated, health planning, regardless of the private interests or investments at stake, is assumed by the federal government. Pre-existing grant programs are used as the "coercive" tool.

The States are given no choice. No state is interested in having its citizens placed in jeopardy. Yet, existing health care education, research and treatment programs will be forfeited if a given state refuses to enter into an agreement with the Appellee Secretary under the "Act." *The choice of denying citizens pre-existing and established health care programs is no choice.* No state could muster the resources necessary to continue the programs currently existing, and which would be denied its citizens if it refused to agree. The States, further, did not accept such programs under the premises of *this* "Act."

Congress has thus "coerced" states to enact "certificate of need" legislation, or, in the case of the State of North Carolina and the State of Nebraska, amend their Constitutions.

Whereas federal law may not be invalid because it may place burdens upon a state to comply, it nevertheless, violates the Tenth Amendment when that law "coerces" the state to legislate. Wrote this Honorable Court in 1926, ". . . neither government may destroy the other nor curtail in any substantial manner the exercise of its powers." *Metcalf & Eddy v. Mitchell*, 269 U.S. 514, 523 (1926).

There simply can be no question that the Constitution, in its entirety, presumes the continued existence of the States. The States are an integral part of the amending process. The Constitution guarantees to each state a republican form of government, and pledges assistance, if requested, against invasion or domestic violence. The new system hammered out in 1787 was to be considered approved when nine of the thirteen States ratified the Constitution. All of the above provisions indicated to the advocates of ratification that "the States would be more than mere administrative districts . . ." Mason, "The Supreme Court and Federalism," 44 *Tex. L. Rev.* 1187, 1197 (July, 1966).

The "understandably apologetic," but forceful opinion of Mr. Justice Miller in the *Slaughter-House Cases*, 83 *U.S.* (16 Wall.) 36 (1972), gives evidence of an implied Constitutional restraint upon the Congress of the United States from interfering in the functions and processes of state governments. Wrote Mr. Justice Miller:

> The argument we admit is not always the most conclusive which is drawn from the consequences urged against the adoption of a particular construction of an instrument. But when, as in the case before us, these consequences are so serious, so far-reaching and pervading, so great a departure from *the structure and spirit of our institutions;* when *the effect is to fetter and degrade the state governments by subjecting them to the control of Congress,* in the exercise of powers heretofore universally conceded to them of the most ordinary and fundamental character; when in fact it radically changes the whole theory of the relations of the state and federal government to each other *and of both these governments to the people:* the argument has a force that is irresistible, in the absence of language which expresses such a purpose too clearly to admit of doubt. (Emphasis added.)

Slaughter-House Cases, supra, at 78.

The above language has been often repeated. *Fry v. United States*, 421 *U.S.* 542 (1975) (Rehnquist dissenting), *Reynolds v. Sims*, 377 U.S. 533 (1964) (Harlan dissenting); *United States v. Darby Lumber Co.*, supra; *United States v. Butler*, 297 *U.S.* 1 (1936).

Though the Association remains philosophically opposed to the expansion of the government of the United States, it is not merely the growth of that government which is at issue. Instead, it is the intrusion of the Congress into, and resulting undermining by the Congress of, those functions of state and municipal governments fundamental and "essential to separate and independent existence" of which it speaks. *Lane County v. Oregon*, supra, at 580.

The Act in question provides no "incentive" upon which States may choose whether or not to participate. It, instead, requires states to enact "certificate of need" legislation, and enter into and renew agreements with the Appellee Secretary, or pre-existing programs, established under separate acts of Congress of the United States, will be dismantled, for, under 42

U.S.C. Subsection 300 m (3) (d), the Secretary "may not make any allotment, grant, loan, or loan guarantee, or enter into any contract under this Act [42 *U.S.C.* Subsection 201 *et seq.*], the Community Mental Health Centers Act [42 *U.S.C.* Subsection 2681 *et seq.*], or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 [42 *U.S.C.* Subsection 4551 *et seq.*] for the development, expansion, or support of health resources in such state until such time as an agreement is in effect."

The National Health Planning and Resources Development Act of 1970, by threatening the withdrawal or non-renewal of existing federal health programs if the States fail to, legislatively and administratively, comply, unduly interferes in the *functions* of state government. Though the Association recognizes those cases cited by the lower Court regarding the federal government's power to impose terms and conditions upon fiscal grants allotted by it to the States,[3] the Association does not believe that that law grants to the Congress any greater authority or power to interfere in the functions of state government than was intended by the organic law of the nation. *The Slaughter-House Cases,* supra. In fact, as stated by this Honorable Court the Constitution prohibits the Congress from exercising its authority in such a manner. *National League of Cities v. Usery,* supra, at 845.

It is still a Constitution we are interpreting! And, unequivocally, "the power granted to Congress was not intended to strip the States of their power to govern themselves or to convert our national government of

[3] *King v. Smith,* 392 *U.S.* 309 (1968); *Oklahoma v. Civil Service Comm'n.,* 330 *U.S.* 127 (1947).

enumerated powers into a central government of unrestrained authority over every inch of the whole nation." *Oregon v. Mitchell,* 400 U.S. 112 (1970).

The National Health Planning and Resources Development Act must be found violative of the Tenth Amendment to the Constitution of the United States and of those historic principles of "federalism" embodied therein.

B. By Requiring the States to Enact Legislation Upon Penalty of Forfeiture of Federal Funding Under A Host of Pre-existing Programs, The National Health Planning and Resources Development Act of 1974 Contravenes the Guaranty Clause of Article IV, Section 4 of the Constitution of the United States.

"Much has been said," spoke Col. George Mason before the Constitutional Convention in June 20, 1787, "of the unsettled state of mind of the people . . ." In two points, however, it was well settled: "1. in an attachment to Republican Government, and 2. in an attachment to more than one branch of the legislature." Farrand, ed.,*Records of the Federal Convention,* I, 339 (New Haven, 1911).

As the new nation's leading exponent of the Constitution, James Madison continued on this theme. He wrote:

> The first question that offers itself is whether the general form and aspect of the government be strictly republican? It is evident that no other form would be reconcileable with the genius of the people of America; with the fundamental principles of the revolution; or with that honorable determination which animates every votary of freedom, to rest all our political experiments on the capacity of mankind for self-government. If the plan of the Convention therefore be found to de-

> part from the republican character, its advocates must abandon it as no longer defensible.

The Federalist, No. 39, 250 (Cook ed., 1967).

Mr. Madison's statements, of course, are directed toward the creation of a federal government, yet his statements illustrate the committment of the American public to republican government. Republican government was a "fundamental principle of the revolution." "Could any further proof be required," wrote Madison, "of the republican complexion of this system. the most decisive one might be found in its '. . . express guarantee of the republican form to each of the [States].'" *The Federalist*, No. 39, 253 (Cook ed., 1967).

Attempts to define republican government have, in the past, met with little success. However, as this Honorable Court stated in *National League of Cities v. Usery*, supra, at 845, there are certain fundamental functions of government "essential to a separate and independent existence." Exemplary of such essential functions are "the right of the people to choose their own officers for governmental administration, and pass their own laws in virtue of the legislative power reposed in representative bodies, whose legitimate acts may be said to be those of the people themselves . . ." *In re Duncan*, 139 *U.S.* 449, 461 (1891). Except where specifically authorized to do so, Congress is powerless to interfere. *Erie R. Co. v. Tompkins*, 304 *U.S.* 64, 78-78 (1938).

The National Health Planning and Resources Development Act of 1974 directs state legislatures to enact "certificate of need" legislation, and, upon enacting such legislation, enter into and renew agreements with the Appellee Secretary regarding the implementation of the "Act." If a state legislature fails to enact the necessary legislation or the state fails to enter into or renew the agreements aforesaid, pre-existing federal health care programs may then be discontinued.

In effect, the "Act" is a Congressional wedge which has been hammered between a state's ability to tax and spend. It removes from the States their essential control over their own destiny, by forcing them to become something akin to administrative districts of a central government. The States, thereby, are severed from their electorate.

Judge Sneed in *Brown v. Environmental Protection Agency*, 521 *F* 2d, 827, 840 (9th Cir., 1975), *cert granted*, 426 *US*. 904 (1976) vacated as moot, 97 *S. Ct.* 1635 (1977) profoundly recited the problem:

> The power of each voter of each state over state expenditures, to the extent not supplied by the federal government, would be less than his power over state taxation. Voters of other states, acting through their representatives in Congress, would dilute the strength of the voters of the states whose revenues would be spent as Congress directs. A structure in which all power on the part of the states to spend was vested in Congress while the power and obligation to tax remained with the States would encourage few even casually acquainted with the writing of Montesquieu and the Republican form of Government. Nor could such an assertion be made were all taxation and expenditure responsibility to reside in the Federal government.

Was not the creation of the Senate in Article I of the Constitution of the United States exemplary of the States' interest in preserving their respective republi-

can integrity? Iredell (N.C.) in Elliot, ed., *The Debates in the Several State Conventions, on the Adoption of the Federal Constitution* (Washington, 1854), IV, 38; Ames (Mass.), Madison (Va.) and Parsons (Mass.) in Elliot, ed., *The Debates in the Several State Conventions, on the Adoption of the Federal Constitution* (Washington, 1854) II, 46, III, 94, 95, II, 26; *The Federalist*, No. 62 at 415 (Cook, ed., 1967). Certainly the inclusion of the "guaranty clause" in Article IV, Section 4, is conclusive.

The "Act" in question, by requiring the enactment of specified legislation by the States, and directing the allocation of state resources and revenues to state agencies, crated under the "Act," separates the taxing from the spending powers. The citizens of the respective states are thus deprived of essential control over state expenditures. Now, large, populous states may veto the activities of smaller states through Congressional pressure. Such amounts to a blatant abandonment of the most fundamental compromise during the Constitutional Convention of 1787. The compact was agreed to by smaller states only upon specific assurances that their relative integrity, as independent sovereigns, would remain undisturbed. Wrote James Madison:

> "... the equal vote allowed (in the Senate) to each state, is at once a constitutional recognition of the portion of sovereignty remaining in the individual states, and an instrument for preserving that residuary sovereignty. So far the equality ought to be no less acceptable to the large than to the small states; since they are not less solicitous to guard by every possible expedient against an improper consolidation of the States into one simple republic.

The Federalist, No. 62. (Cook ed., 1967) at 417.

Where as this Honorable Court was not enabled to examine this immensely important issue in *Brown v. Environmental Protection Agency*, supra, and *Maryland v. Environmental Protection Agency*, 530 *F.* 2d 215 (4th Cir., 1975), *cert granted*, 426 *U.S.* 904 (1976), *vacated as moot*, 97 *S. Ct.* 1635 (1977) though it announced its intention of doing so, the instant appeal draws the issue with clearer, more distinct, lines.

The "Act" in question, under 42 *U.S.C.* Subsections 300 m-2 (a) (1), 300 m-1 (b) (1) and 300 m-1 (b) (4-6), specifically places State agencies, whether federally funded or not, under federal control. There simply exists no appropriate nexus between federal taxation and spending for such pervasive legislation to stand. Congressional power and authority does have limits. Those limits are most readily found in, not the subject matter of the legislation, but, rather, the means by which the power is exercised. As in the instant case, where Congress exercises power so as to interfere with the basic control citizens have over the raising and spending of local revenues, and their security under local, representative government, then the Congress has breached a historic Constitutional "promise" and guarantee to large states as well as small. The "Act" must be found violative of the "guaranty clause of Article IV, Section 4 of the Constitution of the United States.

C. The National Health Planning and Resources Development Act of 1974, By Its Compulsory Regulation of State Heatlh Care Administration and Spending, Undermines the Sovereignty and Vitality of State Government Guaranteed by the Fundamental Structure of the Government of the United States.

Article I of the Constitution of the United States

establishes a bicameral legislative branch of government, assuring for all states a fundamental equality in national representation, and, thereby, protecting against the encroachment by Congress of the sovereignty and vitality of state government. Articles I, II, and III in concert establish the national scheme of government, yet those articles, together, also impose serious limitations upon each of the three coordinate branches of government. Guarantees of personal liberty must be found in the fundamental structure of government just as judical review was so found by implication. *Marbury v. Madison,* 5 *U.S.* (1 Cranch) 137 (1803). *Vested rights* have their historic recognition in the structure of government. Wrote Mr. Justice Story:

> That government can scarcely be deemed to be free where the rights of property are left solely dependent upon the will of a legislative body without any restraint. The fundamental maxims of a free government seem to require that the rights of personal liberty and private property should be held sacred.

Wilkinson v. Leland, 27 *U.S.* (2 Pet.) 627, 657 (1829)'.

Protection of the rights to property is implied. Based upon the history of the drafting and ratification of the Constitution of the United States, is not the sovereignty and legitimacy of the States also implied? The Association submits that the fundamental structure of the government of the United States, when coupled with both the Tenth Amendment and the "guaranty clause" of Article IV, Section 4, admits of no other interpretation.

Arguing against a Bill of Rights, James Wilson, in the Pennsylvania Ratifying Convention, stated that the people clearly limited the delegation of power in

the new federal constitution. "Congressional power," he said, "is to be collected . . . from the *positive* grant expressed in the instrument of the union." Wood, *The Creation of the American Republic,* 1776-1787, 559 (Chapel Hill, 1969).

If, as the Preamble states, the power of Congress emanates from that which was explicitly surrendered by the people, and, the states antedated the creation of the compact of union in which compact they are guaranteed a republican form of government, reserved powers not surrendred or retained by the people, and made necessary components in the ratification and amending processes, then does not logic command the argument which, like the doctrine of *vested rights,* holds that the fundamental structure of government, irrespective of the Tenth Amendment, guarantees the continued sovereignty and vitality of the States? The Association firmly believes that such an implied guarantee exists, and that this Honorable Court specifically recognized it in *National League of Cities v. Usery,* supra.

Neither the "commerce clause" of Article I, Section 8, clause 3, nor the "taxing and spending power" of Article I, Section 8, Clause 1 may overcome that sovereignty reserved in the several states by the people. Therefore, based upon the fact that the states existed prior to the federal convention of 1787; that those states were represented therein; that the states remained a necessary component of both the ratification and amending processes; that the states were guaranteed a republican form of government and protected against domestic violence; that they were reserved power not surrendered to the government of the United States or reserved by the people; and, that all national power

was specifically derived from the "supreme authority of the people themselves," and through the people, the continued existence of the states was, constitutionally, recognized, any attempt by the Congress to undermine the function of state government is violative of that popular command embodied in the Constitution. See: Madison, Gorham, King, Williamson, and Morris, in Farrand, ed., *Records of the Federal Convention,* II, 93, 90-92, I, 123, II, 476, 92, 93, II, 92, 93, I, 123 (New Haven, 1911).

By "coercing" states to enact specific legislation and controlling the expenditure of state revenues in the field of health care, the Congress has proceeded beyond its fundamental grant of power and authority. The people specifically did not deliver unto the Congress of the United States the power to interfere with, impede or undermine the functions of state government.

The method the Congress has chosen to implement its program is abusive to that structure of government created, preserved and protected by the people. The "Act" is thus violative of those enumerated powers embodied in Article I of the Constitution of the United States, and of that structure of government, both expressed and implied, created by that compact of union.

II.

THE FEDERAL GOVERNMENT AND THE INDIVIDUAL

The Constitution of the United States, through the Doctrine of Separation of Powers, Reaffirms the Principle that the Doctrine of *Vested Rights* is preeminent in Our Organic Law.

The Association submits to this Honorable Court

that the Constitution of the United States, in its establishment of the three coordinate branches of government, was designed, quite independently of the Bill of Rights and the Fourteenth Amendment, to protect the properties and advance the liberties of citizens. As all national powers are derived specifically from the people, those powers so surrendered were enumerated. Those that were not surrendered were specifically reserved by the people. Such was later expressed explicitly in the Ninth and Tenth Amendments. Therefore, as Congress, through its enumerated powers might reflect majority will, that will could not be superior to the sum of its parts!

The people reserved for themselves, individually, the right to acquire and possess property, and ordained and established the Constitution, in order to, among other things, "secure the Blessings of Liberty."

Again, independent of the Bill of Rights and the Fourteenth Amendment, the Constitution of the United States provided for a "general restraint" upon the legislature in favor of private rights. Spoke Daniel Webster while arguing the case of *Wilkinson v. Leland,* supra, at 646-647:

> If, at this period, there is not a general restraint on legislatures, in favor of private rights, there is an end to private property. Though there may be no prohibition in the Constitution, the legislature is restrained from acts subverting the great principles of republican liberty and of social compact.

The underlying doctrine of American Constitutional Law, a doctrine without which, indeed, it is inconceivable that there would have been any Constitutional Law, is the doctrine of *vested rights.* Corwin,

"A Basic Doctrine of American Constitutional Law," 12 *Mich. L. Rev.* 247 (1914). The fundamental character of the property right was asserted repeatedly on the floor of the federal convention. Farrand ed., *Records of the Federal Convention*, I, 424; 533-534, 541-542, II, 123 (New Haven, 1911). It was thus not accidental that the doctrine of *vested rights* was brought within the purview of the Constitution by a member of that convention, namely, Mr. Justice Patterson, in *Van Horne's Lessee v. Dorrance*, 2 *U.S.* (2 Dall.) 304, 310 (1795). Mr. Justice Patterson stated:

> The right of acquiring and possessing property and having it protected is one of the natural, inherent and unalienable rights of man. Men have a sense of property: property is necessary to their natural wants and desires; its security was one of the objects that induced them to unite in society. No man would become a member of a community in which he could not enjoy the fruits of his honest labor and industry. The preservation of property, then, is a primary object of the social compact.

As Chancellor Kent wrote, "Liberty depends essentially upon the structure of government . . ." Corwin, "A Basic Doctrine of American Constitutional Law," 12 *Mich. L. Rev.* 247, 262 (1914), *c.f.* Kent, *Commentaries*, 332.[4]

The National Health Planning and Resources De-

[4]Such a doctrine represented the "point of view of the founders of American Constitutional Law who saw before them the same problem that had confronted the convention of 1787, namely, the problem of harmonizing majority rule with minority rights, or more specifically, republican institutions with the security of property, contracts and commerce." Corwin, "A Basic Doctrine of American Constitutional Law," 12 *Mich. L. Rev.* 247, 276 (1914; See Also: Corwin, "The Higher Law Background of American Constitutional Law," 42 *Harv. L. Rev.* 365, 390 (1928-1929).

velopment Act of 1974 requires each state to enact "certificate of need" legislation under which no health care facility may be built, equipped, expanded, or modernized without state approval. The program applies to all institutional health care services whether government funded or not. 42 *U.S.C. Su*bsection 300 m-2 (a). Even a private citizen using private funds to build a private clinic may be forbidden from doing so if the state agency, through the Appellee Secretary, finds the clinic not "needed."

Under the "Act" the state agency is given authority to determine whether "existing facilities" — even private facilities — "are in need of modernization or conversion to new uses." 42 *U.S.C.* Subsection 300 o-2 (a) (4) (C). The Association submits that a substantial number of its members own and operate private clinics and hospitals which receive no government funding whatsoever. Those individuals are in danger of losing the very private character of their property, and, hence the property itself.[5]

The Constitution of the United States, by its very spirit and meaning, prohibits legislative interference in the acqusition and mantenance of private property. There does exist a *vested right* to acquire and protect private property. It is a fundamental reason for social compact. Nowhere could it be plausibly found that the people surrendered such rights of control over their

[5]Private property can, under this "Act" be "eliminated." See: 4 *U.S. Code Congressional and Administrative News*, 7842, at 7890 (93rd Congress, Second Session, 1974). Where it is stated: "If a state health planning and development agency acts to modify or discontinue any existing health facility, institutional health service, or health maintenance organization, the local health planning agency is directed to assist the affected entity in improving or eliminating such service."

property to the Congress. The inclusion in the Constitution of the United States of the Fifth and Fourteenth Amendments only confirmed this time-honored principle.

For the Congress to so interfere in the acquisition and possession of private property contravenes a *vested right* as old as *Magna Charta*, and recognized in the structure of the federal government as well as in both the Fifth and Fourteenth Amendments to the Constitution of the United States. Manifestly, the "certificate of need" device simply cannot be used to convert a private facility into a public one. *Frost & Frost Trucking Co. v. Railroad Commission*, 271 *U.S.* 583 (1926); *Smith v. Cahoon*, 283 *U.S.* 553 (1931).

III.

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 INVADES THE PROTECTED PRIVACY, AND PROFESSIONAL DECISION-MAKING PROCESS OF THE PRACTICE OF MEDICINE, AND, EMPOWERS THE UNITED STATES WITH AUTHORITY, PROHIBITED BY THE CONSTITUTION, TO IMPAIR THE INDIVIDUAL'S VESTED RIGHT TO PRACTICE MEDICINE

The Association submits to this Honorable Court that Congressional power to enter the field of national health planning appears in doubt. The effect of the National Health Planning and Resources Development Act of 1974 will be felt not only by institutional health care providers who may or may not be funded at all by the federal government, but also by practitioners of private medicine. To them there is no "option" under this legislation.

Traditionally, the state had a narrow interest in controlling the delivery of health care and the practice

of medicine. As stated in *Dent v. West Virginia*, 129 *U.S.* 114, 121-222 (1889):

> It is undoubtedly the right of every citizen of the United States to follow any lawful calling, business, or profession he may choose, subject only to such restrictions as are imposed upon all persons of like age, sex and condition. This right may in many respects be considered as a distinguishing feature of our republican institutions. Here all vocations are open to every one on like conditions. All may be pursued as sources of livelihood, some requiring years of study and learning for their successful prosecution. The interest, or, as it is sometimes termed, the estate acquired in them, that is, the right to continue the prosecution, is often of great value to the possessors, and cannot be arbitrarily taken from them, any more than their real or personal property can be thus taken.

See also: *Meyer v. Nebraska*, 262 *U.S.* 390, 399 (1923); and *Barsky v. Board of Regents, of the State of New York*, 347 *U.S.* 442, 459 (1954) (Black, dissenting).

Regulation of the practice of medicine has been, historically, a state function, but limited to assuring that "only properly qualified persons shall undertake its responsible and difficult duties;" that standards of conduct are maintained, and patients' health and safety are guarded. *Watson v. State of Maryland*, 218 *U.S.* 173, 176 (1910); *Polhemas v. American Medical Association*, 146 *F* 2d 357 (9th Cir., 1944) and *New Jersey Chiropractic Ass'n. v. State Board of Medical Examiners of N.J.*, 79 *F. Supp.* 327 (D.C.N.J., 1948).

Protection of the physician's "right to administer treatment according to his professional judgment" has been explicitly recognized by this Honorable Court.

Roe v Wade, 410 *U.S.* 113, 165-166 (1973). Third parties, therefore, have been denied the power to intrude into decisions between a physician and his patient. *Planned Parenthood v. Danforth*, .. *U.S.* .., 96 S. Ct. 2831 (1976).

The Congress under the National Health Planning Act of 1974 is attempting to accomplish two objectives: (1) to remove from the States any limited regulatory power it could exercise under its powers of police; and (2) directly invade the practice of private medicine by placing the government of the United States squarely between the physician and his patient. Under 42 *U.S.C.* Subsection 300 k-1 the Appellee Secretary is empowered with the authority to issue "guidelines concerning national health planning." Included therein will be "standards respecting the appropriate supply, distribution, and organization of health resources." In establishing goals for "national planning," Congress, under 42 U.S.C. Subsection 300 k-2, listed ten such goals including the "development of multi-institutional systems for coordination or consolidation of institutional health services" and the "adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions." The goals, among others, are to accomplish the stated purposes of Congress which are to develop "uniformly effective methods of delivering health care;" redistribute "health care facilities and manpower" and lower the cost of health care. 42 U.S.C. Subsection 300 k (a) (3) (A) (B) (C). Health Systems Agencies, State Health Planning and Development Agencies and Statewide Health Coordinating Councils, required to be established under the "Act," are responsible for implement-

ing those goals and priorities. 42 U.S.C. Subsections 300 1-2, 300 m-2, 300 m-3 (c). All such agencies are created according to the requirements of the "Act." and are answerable, ultimately, to the Appellee Secretary. 42 U.S.C. Subsections 300 1-1 through 300 1-4, 300 m through 300 m-2, 300 m-3 through 300 m-5.

Though the withdrawal of pre-existing grant programs are used by Congress to force the States to enact requisite "certificate of need" legislation and enter into the required agreements with the Secretary, the immense effect and impact of this legislation is directed toward the *health care providers* who, in large part, are private individuals or organizations. Congress has developed no fiscal nexus with the private practitioner to implement such pervasive legislation.

The effect of the "Act" simply cannot be reconciled with this Honorable Court's rigid recognition of the physician's right to administer treatment according to his professional judgment. *Roe v. Wade*, supra; *Planned Parenthood v. Danforth*, supra. "Certificate of need" decisions, by controlling the "appropriate supply, distribution and organization of health resources," necessarily restrict, and potentially veto, physicians' judgments regarding diagnosis, treatment and hospitalization. The magnitude of federal power and authority over the practice of private medicine found in the "Act" is limited only by the extent of one's imagination.

Where, the Association asks, has that sanctity and privacy fundamental in the practice of medicine been respected by Congress in the enactment of this "Act"? This Honorable Court has, in the past, stated the "certificate of need" device cannot be utilized to convert a

private facility into a public one. ***Frost & Frost Trucking Co. v. Ralroad Commission***, 271 U.S. 583 (1926); and see *Smith v. Cahoon*, 283 *U.S.* 553 (1931). Likewise, the Congress cannot utilize such a device to convert the practice of private medicine and the limitless decisions and considerations embodied therein into a public enterprise. Is there not an "estate" created in the practitioner with reference to his practice? ***Dent v. West Virginia,*** supra. Is not the professional judgment of a physician immune from third-party interference? *Roe v. Wade*, supra.; and *Planned Parenthood v. Danforth*, supra. What "option" not to participate has been offered by Congress under the "Act" to the private physician or health care organization?

The Appellee relies heavily upon the language of Mr. Justice Cardozo in *Steward Machine Co. v. Davis*, 301 *U.S.* 547 (1937) to illustrate the "national dimensions" of the problems in health care. Whereas the Association has always regarded the aforementioned decision as based on expediency rather than law, it, nevertheless, submits that the use of the case has no merit. Congress, in the "Act" in question, has, itself admitted that "the massive infusion of *Federal funds* into the existing health care system has contributed to inflationary increases in the cost of health care . . ." 42 *U.S.C.* Subsection 300 k (a) (2). Where shall we draw the line? How many persons shall lose their liberty and property because Congress indulged itself too freely in the spending of money? The Association submits that, constitutionally, Congress cannot invade the privacy of the practice of medicine; nor can it interpose its veto upon the professional judgment of a practitioner of private medicine. Likewise, the Association

submits, Congress cannot, constitutionally, "redistribute," "consolidate," "coordinate" or control the delivery of health care services without impairing *vested rights* to property heretofore recognized by this Honorable Court. Unless the Court accepts Franklin Roosevelt's assertion that the "right to adequate medical care and the opportunity to achieve and enjoy good health" is embodied in our organic law,[6] and may supercede basic political and property rights, then the "Act" must be declared unconstitutional as violative of the fundamental structure of government, and the First, Fifth, Ninth and Tenth Amendments to the Constitution of the United States.

It is known by all citizens of this republic that, since 1932, there has been an explosive growth of federal bureaucracy and control, costing hundreds of billions of dollars to finance. Is the price citizens of this republic must pay for the failure of those programs or the inflation created by such programs to be the loss of property and *vested rights?* The practice of medicine remains an endeavor the privacy of the decisions in which are protected by the First, Ninth and Tenth Amendments. Additionally, the practice of medicine itself, outside of considerations of consumers' interests in safety and competence of practitioners, remains a vested property right protected by the structure of government and the Fifth, Ninth, Tenth and Fourteenth Amendments.

The arbitrariness of the "Act" may well be found

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[6]**Message from the President of The United States on The State of the Union, H.R. Doc No. 377, 78th Cong., 2d Sess,, in 90*Cong. Rec.* 55 (1944).**

in its purpose clauses as well as in the fact that the health care providers who are being regulated and controlled are given no "options." The "Act" forces compliance, and must be declared unconstitutional.

CONCLUSION

For all the foregoing reasons, the Association of American Physicians and Surgeons, Inc., as *Amicus Curiae,* respectfully requests this Court to note probable jurisdiction and declare the National Health Planning and Resources Act of 1974 unconstitutional.

Respectfully submitted,

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